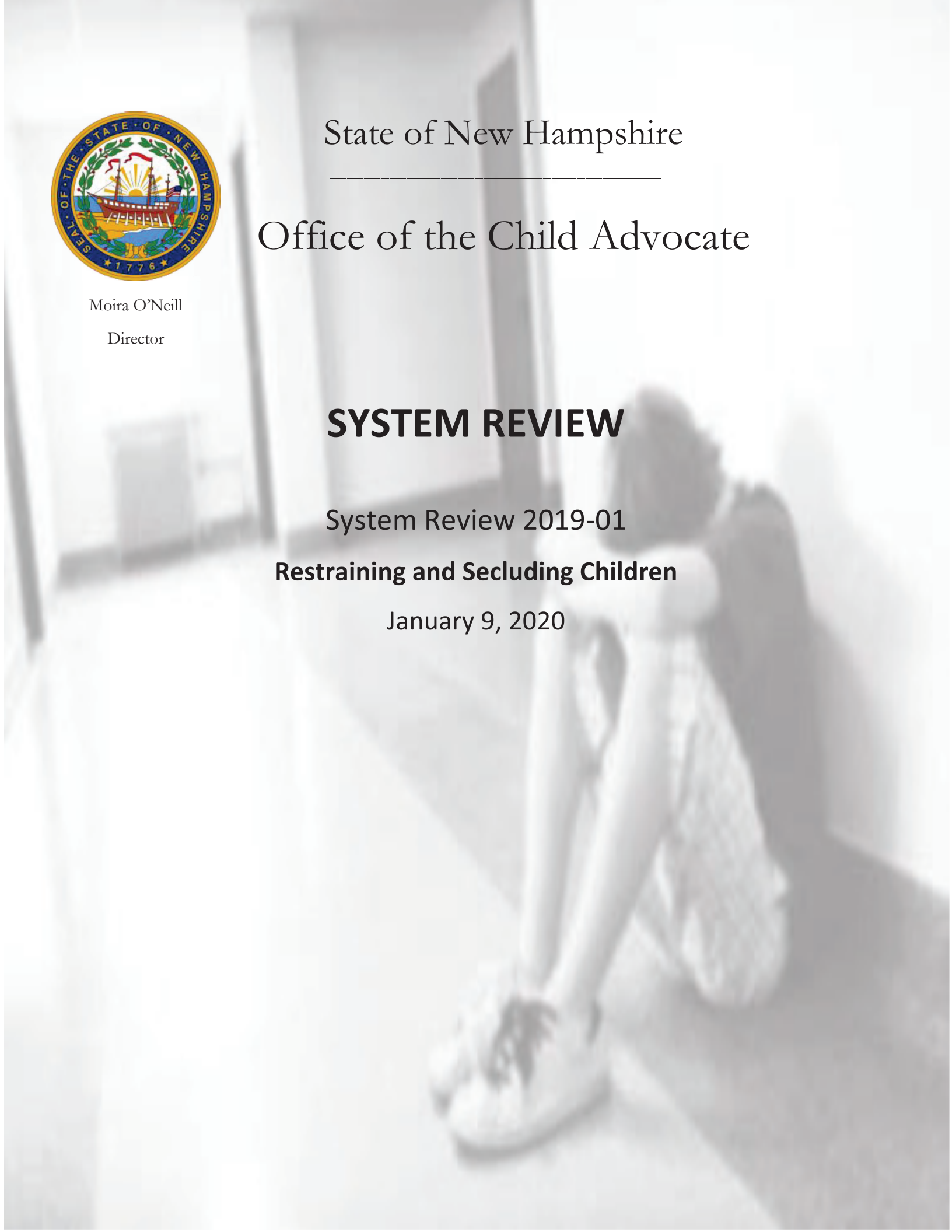

State of New Hampshire

Office of the Child Advocate

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Director

SYSTEM REVIEW

System Review 2019-01

Restraining and Secluding Children

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FOREWORD

Through the lens of child welfare there are layers of safety nets employed to ensure parents are doing what they need to do to keep children safe. At school, recreation programs, churches, and all the community intersections a child encounters, people are watching after the children and, when needed, will step in to offer assistance or prompt protective action. When children are removed from their home and community for whatever reason, it falls to the State child welfare system to ensure safety and well-being at an even higher standard than parents would be expected to provide, because just leaving home sets a child back in the trajectory of development. Children placed in institutional settings are hidden from community view. Children who are institutionalized have the highest risk of being restrained,[1] and yet the restraint and seclusion of children placed in institutional settings is a hidden practice. The incidence of restraint and seclusion in New Hampshire may therefore come as a surprise.

"I don't want to get hurt any more in restraints. My shoulder still hurts." *Child in residential facility*

In a five year period between 2014 and 2018 there were more than 20,000 incidents of children being restrained or secluded in New Hampshire residential facilities, most of them, 15,544, were restraints.[2] Acknowledging the dangers of restraint and seclusion to both children and staff, New Hampshire put a law in place, RSA chapter 126-U, to ensure limited use of these practices, careful collection of information about each incident, periodic review of facility practices, and transparent reporting to state decision makers. However, the Department of Health and Human Services (department) declined to adopt statutorily mandated rules to guide its oversight of facility practice and reporting. An annual report to the legislature is only an aggregate sum of restraints and seclusions in a year. The reports lack the informing details that give meaning to what happened, to whom, by whom, why and what came next. There has been no examination of the reports to determine effectiveness of the law or assess the risks and benefits of the practice of restraining or secluding children behind closed doors. Children arrive in residential treatment facilities with a significant history for adverse childhood experiences (ACE), placement out of home being one of them. Children in these facilities have been exposed to substance use, mental illness, domestic violence and abuse and neglect. They experience trauma or diagnosed post-traumatic stress disorder at a rate more than twice that of combat veterans.[3] They may suffer from hyperactive, impulse and dysregulation disorders, sensory disorders, depression,

[1] Roy, C., Castonguay, A., Fortin, M., et al. (2019). The Use of Restraint and Seclusion in Residential Treatment Care for Youth: A Systematic Review of Related Factors and Interventions. *Trauma, Violence, & Abuse*. https://journals.sagepub.com/doi/10.1177/1524838019843196#_i21

[2] Accounts of restraint and seclusion incidents were sourced from Annual Reports Pursuant to RSA 126-U submitted by the Department of Health and Human Services to the Chairs of the House Children and Family Law and the Senate Health and Human Services Committees.

[3] Purvis, KB, Cross, DR, Dansereau, DF & Parris, SR, (2013). Trust-based relational intervention (TBRI): A systemic approach to complex developmental trauma. *Child & Youth Services*, 34(4): 360-386. DOI: 10.1080/0145935X.2013.859906.

anxiety, suicidality, and other psychopathologies.[4,5] Restraints and seclusion traumatize or re-traumatize children, setting back recovery.[6] However, children are not the only victims in restraint and seclusion incidents. Staff are also routinely injured. They suffer in other ways that severely affect the stability of the workforce and the cost of operating a treatment facility.

Perhaps most concerning, the use of prone (face down) restraints, a potentially lethal and certainly dehumanizing practice, is still in use in New Hampshire. Prone restraints are banned in many states. New Hampshire law stops short of using the word prone. However, it prohibits physical restraint that obstructs a child's airway, impairs breathing, places pressure or weight on upper body or obstructs blood circulation, all of which occur when a child is restrained in a prone position. At least four providers and the Sununu Youth Services Center (SYSC) (New Hampshire's correctional facility for children) continue to restrain children in prone positions, suggesting either a refusal to comply with the law or different interpretations in terms of its use. In 2019, the department issued an advisory statement to residential providers recommending against the use of prone restraints, but not forbidding it. One department staff member reported to the Office of the Child Advocate (OCA) that the department has no current plans to address continued use of prone restraint. The staff member also suggested to the OCA that prone restraints are not unsafe so long as people are trained to use them. The meaning of "safe" is dubious in the trajectory of child development and state care.
On February 14, 2018, the newly established OCA met with Division for Children, Youth and Families (DCYF) administrators for the first time and began pursuing the department's compliance with RSA Chapter 170-G:18 to report incidents to the OCA within 48 hours of occurrence. Over time, the OCA learned that the department had no centralized surveillance system of incidents and was therefore, unable to comply with the law. More importantly, although facilities might report individual occurrences to child protection case workers (CPSW) or juvenile probation and parole officers (JPPO), without a centralized repository and with high turnover, no one was consistently watching out for children in residential care from a broader view.

In May 2019, the OCA opened a system review of the use and reporting of restraint and seclusion of children in residential care, later releasing a briefing on the review in September 2019. As the review's targeted completion date approached in December 2019, nearly two years after the OCA commenced requests for compliance with the law, the department announced the creation of a system to store incident data, including individual reports of restraint and seclusion. The initial plan is to cull data from private residential facility reports to a spreadsheet for monitoring, and work toward a web-based reporting system. The reports, in turn, will be forwarded to the OCA. The OCA began receiving notice of incidents at private residential facilities on December 12, 2019. The process does not accommodate the prescribed 48-hour timeline. Very few provider reports on restraint and seclusion have reached the OCA thus far, but it is a start. Although pursuant to RSA 170-G:18, III(d) the OCA shall have prompt electronic

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[4] Connor, DF, Doerfler, LA, Toscano Jr., PF, Volungis, AM & Steingard, RJ, (2004). Characteristics of children and adolescents admitted to a residential treatment center. *Journal of Child and Family Studies*, 13(4): 497-510. DOI: 10.1023/B:JCFS.0000044730.66750.57

[5] Cohen, JA, Mannarino, AP, Jankowski, K, Rosenberg, S, Kodya, S, & Wolford II, GL, (2016). A randomized implementation study of trauma-focused cognitive behavioral therapy for adjudicated teens in residential facilities. *Child Maltreatment*, 21(2): 156-167. 156–167. doi:10.1177/1077559515624775.

[6] Substance Abuse and Mental Health Services Administration, (2011). *The Business Case for Preventing and Reducing Restraint and Seclusion Use*. HHS Publication No. (SMA) 11-4632. Rockville, MD: Substance Abuse and Mental Health Services Administration.

access to records within the scope of its mission, the spreadsheet with incident data is being stored in an electronic shared drive that the department has denied the OCA access to for nearly two years.

Despite the delays of infrastructure and lack of compliance, the reports that are coming through are telling. In the first batch of reports, the OCA learned of a 13-year-old child who returned to a private facility from a visit with a parent and siblings in a state of emotional upset. Over a two-day period, the child was restrained twice due to disruptive and assaultive behavior. Home visits were described in the reports as a triggering factor. The reports also noted the child's unwillingness or inability to process the home visits. By coincidence, the OCA had received a request of assistance in a case of another child who was repeatedly returning from parent and sibling visits with severe mood and behavior concerns. Upon review, the OCA discovered the children were siblings, each placed in a different setting. As the children's conditions worsened and developmental gains were lost, the disruptive visits continued on schedule to allow the parent visitation in accordance with legally required reunification efforts. Reports of visits described chaotic sessions during which the parent berated the children and demonstrated no skills for managing behavior. A therapist and a caregiver advocated to change the visits and adjust therapeutic support for one sibling. Their actions are documented in the child's DCYF record. There is no documentation residential staff advocated adjusting visits for the other sibling, despite the resulting behavior that preceded repeated incidents of restraint. None of the parties are documented as reaching out to each other to determine solutions for whole-family distress. The OCA's access to this information from multiple sources allowed a broad view of the family situation and opportunity to bring it to DCYF's attention. It also confirmed the necessity of centrally watching out for the children in state care, collecting data, identifying trends, and making connections for better care and protection.

There is progress. Some residential providers have announced changes in the way they use the practices or whether they will continue to use them at all. Some have defended their practices. There is a long way to go. The path ahead includes a significant shift away from the acceptance of a need for physical force and external control. Prevention of problem behaviors, rather than exacerbating them will position children for positive outcomes. The science of brain development reveals children with traumatic pasts are physiologically wired for problem behaviors and emotional dysregulation. Children can be resilient however, but resiliency depends upon trusting relationships and nurturing their own internal controls and coping strategies. Closed doors and use of physical restriction are not sustainable or effective means of safety from legal or clinical perspectives, nor, more importantly, from the children's perspective. In the meantime, New Hampshire allocated funds in 2019 through the passage of Senate Bill 14, in order to expand the community-based system of care. Implementing the expansion will better support children and their families at home where they belong, avoiding the institutional placements that contribute to risk of restraint and seclusion.

Upon review of practices within the state, the infrastructure for oversight of those practices, and the latest research on the use of restraint and seclusion, the OCA makes the following recommendations. These recommendations aim to minimize the use of restraint and seclusion of children to optimize child wellbeing, promote safe workplaces, and curb unnecessary state expenditures.

Minimize Trauma

- Implement community-based system of care expansions outlined in 2019 Senate Bill 14 and promote effective alternatives to institutional placements (department)
- Enhance department staff training, including Sununu Youth Services Center (SYSC) staff, in child development with emphasis on brain development and impact of trauma, (department)

Adopt and Clarify Language

- Adopt and clarify language in contracts, guidance, policy, procedure and adopted rules to clearly articulate the expectation of minimizing and eliminating restraint and seclusion and, as per RSA 126-U, prohibiting restraints equating to prone restraint (department, providers)

Incentivize Culture Change

- Sponsor training in child development, trauma, and trust-based relational interventions for residential treatment staff in a shift to trust-based, trauma-sensitive, developmentally informed, effective care and treatment models (department, providers)
- Capitalize on existing educational infrastructure in the DCYF-Granite State College training programs by extending opportunities to all residential treatment staff. (department, providers)
- Promote, monitor and hold accountable residential treatment facilities seeking to achieve status as a federally qualified residential treatment program under the Family First Prevention Services Act, including support for coaching consultants for shifting culture (department)

Facilitate Meaningful Surveillance

- Adopt rules pursuant to RSA 126-U:9, policies and/or practice guidance for reporting incidents, reviewing practices, investigating abuses, ensuring remedial and protective measures, and receiving complaints (department)
- Conduct periodic, reviews of facility practices and reports in accordance with RSA 126-U:9, II for the basis of the annual report regarding the use of restraint and seclusion (department)
- Develop a web-based standardized reporting mechanism for provider ease of reporting incidents with consistent, meaningful data, including facility census (department)
- Comply with 170-G:18 by providing the OCA immediate access to records, including the shared drive where incident data is currently being stored (department)
- Develop a monitoring system to oversee all children placed in institutional settings, including those placed by school districts (legislature, department, Department of Education)
- Establish a collaborative for regular review of restraint and seclusion incidents. Include the department, providers, the OCA, the DRC, individuals who, as children, experienced residential placement, and families (department)
- Develop a process for children currently in the system to share their experience and make recommendations to the collaborative (department)
- Examine the logistical obstacles to the department's mandate of 48-hour incident reporting to the OCA under RSA 170-G:18, IV(a) and adjust the mandate, if necessary (legislature, department, OCA)

Incident Narrative A.

"Josh" (All names of children are changed to protect privacy)

"Josh" sat on a chair in a communal room. Facility staff noted Josh was being disrespectful and asked him to go to his room. Josh refused. Staff reports described attempts to verbally de-escalate Josh. Staff reported that it was clear Josh was not going to follow staff directives and called a code for assistance. Additional staff arrived and attempted to talk with Josh. Staff reported Josh continued to resist complying and was balling up his hands into fists. Josh remained seated in the chair. Staff approached Josh and took hold of each arm bringing Josh to the standing position. Josh swung his head back and hit one staff member in the eye. Staff then placed Josh on the floor in the prone position. Staff reported Josh struggled and made threats of harm to staff, prompting them to place the boy in handcuffs. Staff lifted Josh up off the floor and escorted him to his room. Shortly thereafter, staff escorted Josh to a different unit and removed the handcuffs.

In processing the restraint incident, staff disclosed Josh may have been upset about having a personal family memento removed from his room.

PURPOSE OF SYSTEM REVIEW

This System Review examined the meaning, purpose, use and reporting of restraint and seclusion of institutionalized children and the relevant law, RSA chapter 126-U. The physical and psychological effects of restraint and seclusion are also considered. As with other states, New Hampshire law includes restrictions on the use of restraint and seclusion, and reporting requirements when such measures are taken in strictly defined circumstances. This review examined the meaning of those restrictions and the need for reporting in order to protect children in care from abuse or neglect by the state of New Hampshire or its agents. The future landscape of restraint and seclusion in New Hampshire is postulated with learning points identified. Ultimately, and in accordance with best practice standards,[7] the OCA aims to promote the elimination of the practice of restraint and seclusion on children in all facilities wherever possible. This review will explain why that is necessary in the context of brain development, trauma, and other relevant empirical evidence.

[7] American Psychiatric Nurses Association, (2014). Standards of Practice: Seclusion and Restraint. Accessed at https://www.apna.org/files/public/APNA_Seclusion_&_Restraint_Standards_of_Practice.pdf; Joint Commission (2019). Standards and Elements of Performance for Restraint Accredited as a Behavioral Health Program; U.S. Department of Education, (2012). Restraint and Seclusion: Resource Document, accessed at https://www2.ed.gov/policy/seclusion/restraints-and-seclusion-resources.pdf

RESTRAINT & SECLUSION OF CHILDREN DEFINED

Restraint is defined in New Hampshire Law as "bodily physical restriction, mechanical devices, or any device that immobilizes a person or restricts the freedom of movement of the torso, head, arms, or legs. It includes mechanical restraint, physical restraint, and medication restraint used to control behavior in an emergency or any involuntary medication. It is limited to actions taken by persons who are school or facility staff members, contractors, or otherwise under the control or direction of a school or facility." *RSA 126-U:1, IV*

RSA 126-U:5 Limitation of the Use of Restraint to Emergencies Only
I. Restraint shall only be used in a school or facility to ensure the immediate physical safety of persons when there is a substantial and imminent risk of serious bodily harm to the child or other. The determination of whether the use of restraint is justified under this section may be made with consideration of all relevant circumstances, including whether continued acts of violence by a child to inflict damage to property will create a substantial risk of serious bodily harm to the child or others. Restraint shall be used only by trained personnel using extreme caution when all other interventions have failed or have been deemed inappropriate.
II. Restraint shall never be used explicitly or implicitly as punishment for the behavior of a child.

126-U:4 Prohibition of Dangerous Restraint Techniques
No school or facility shall use or threaten to use any of the following restraint and behavior control techniques:
I. Any physical restraint or containment technique that:
(a) Obstructs a child's respiratory airway or impairs the child's breathing or respiratory capacity or restricts the movement required for normal breathing;
(b) Places pressure or weight on, or causes the compression of, the chest, lungs, sternum, diaphragm, back, or abdomen of a child;
(c) Obstructs the circulation of blood;
126-U:4, I(a)-(c)

Seclusion is defined as "the involuntary placement of a child alone in a place where no other person is present and from which the particular child is unable to exit, either due to physical manipulation by a person, a lock, or other mechanical device or barrier." *RSA 126-U:1, V-a*

RSA 126-U:5-a Limitation on the Use of Seclusion
Seclusion may not be used as a form of punishment or discipline. It may only be used when a child's behavior poses a substantial and imminent risk of physical harm to the child or to others and may only continue until that danger has dissipated. Seclusion shall only be used by trained personnel after other approaches to the control of behavior have been attempted and been unsuccessful, or are reasonably concluded to be unlikely to succeed based on the history of actual attempts to control the behavior or a particular child. Seclusion shall not be used in a manner that unnecessarily subjects the child to the risk of ridicule, humiliation, or emotional or physical harm.

THE ROLE OF STATE GOVERNMENT

The Division for Children, Youth and Families

DCYF is responsible for administering child protection and juvenile justice services. There are three chapters in New Hampshire law that place expectations of assistance to children on DCYF. It is clear in the language that assistance to children is meant to be therapeutic, sensitive, and rehabilitative to promote optimal growth and development.

- RSA 169-B:1, I, governing children who are delinquent, requires DCYF, "encourage the wholesome moral, mental, emotional, and physical development of each minor coming within the provisions of th[e] chapter, by providing the protection, care, treatment, counselling, supervision, and rehabilitative resources which such minor needs."
- RSA 169-C:2, III(a) governing child protection, requires DCYF, "encourage the mental, emotional, and physical development of each child coming within the provisions of th[e] chapter, by providing him with the protection, care, treatment, counselling, supervision, and rehabilitative resources which he needs and has a right to receive."
- RSA 169-D:1, I, governing children in need of services, requires DCYF, "provide the child with the treatment, care, guidance, counseling, discipline, supervision, and rehabilitation necessary to assist him in becoming a responsible and productive member of society."

DCYF aims to prevent and mitigate child abuse, neglect or adjudication but also responds to children's needs on a variety of levels, including taking children into custody and placing them in institutional settings generally referred to as "residential treatment." Each year, approximately 400 children are placed in residential treatment.[8] The department licenses residential facilities in New Hampshire. Licensing generally assures basic conditions such as the safety of the food, water and the physical plant. DCYF further certifies all facilities in New Hampshire and any other states where DCYF places children. Certification is required in order for the facility to be eligible for Medicaid reimbursement. The department-licensed capacity of a facility is greater than DCYF certified capacity because each facility also admits children referred by their schools or from other states. Restraint and seclusion data in this review includes incidents involving children placed by all sources.

Authority of the Office of the Child Advocate

Pursuant to RSA 170-G:18, III(a), the mandate of the Office of the Child Advocate (OCA) is to "[p]rovide independent oversight of the division for children, youth, and families to assure that the best interests of children are being protected." To carry out its duty, the OCA has the authority under RSA 170-G:18, III(i) to "review and if deemed necessary, investigate the actions of [DCYF] or any entity that provides services to children under contract with and at the direction of the division." DCYF's responsibility to the OCA is to "provide the office with a copy of all incident or other reports related to actual physical injury to children or a significant risk of such harm, as well as other incidents which may affect the safety and well-being of children in the custody or control of the department not later than 48 hours after the occurrence; provided that any child fatality or serious injury shall be immediately communicated to the office by telephone."[9] By agreement, reportable incidents are interpreted to include restraints and seclusion. Upon receipt of reports, including incidents of restraint and seclusion, the OCA reviews and

[8] Data source: DHHS Results Oriented Management System (ROM)
[9] RSA 170-G:18, IV(a).

determines whether further investigation is required. Over time, the OCA monitors events for trends indicating need for system improvement. The OCA is unable to review any incidents that are not reported to the office unless discovered in the course of another investigation.

Beginning in February 2018, the OCA sought DCYF compliance with incident reporting. It was an agenda item in monthly meetings with DCYF administrators, addressed in an agreement defining incidents, discussed in testimony before the Oversight Commission on Children's Services, and described in the OCA 2018 Annual Report. Until December 12, 2019, the OCA only consistently received reports of child deaths, other critical incident reports, and all incidents occurring at the SYSC, including restraints and seclusion. Other than the annual aggregate report of restraint and seclusion incidents, the OCA received only rare reports of incidents occurring at private residential facilities. The OCA, therefore, has not been able to provide adequate oversight of children who have been restrained or secluded, or the practices of residential treatment facilities, in a systematic way.

CHILDREN: WHAT THEY NEED AND RISKS THEY FACE

Children in Residential Treatment

Although nationally and in New Hampshire, child welfare and juvenile justice reform emphasize care of children in their homes and communities, a persistent number are still placed in residential treatment facilities. The majority of children, whether through child protection, juvenile justice services, or schools, are placed to address behavior, developmental disability, or chronic mental health conditions. Children placed at the SYSC by court order have exhibited behavior considered criminal or allegedly criminal, therefore requiring detention or commitment in the locked facility.

The general profile of an institutionalized child is characterized by a history of exposure to family dysfunction including substance use, mental illness, domestic violence and abuse and neglect, including a high rate of sexual abuse. Children placed in institutional settings experience trauma or diagnosed post-traumatic stress disorder at a rate more than twice that of combat veterans.[10] They are more likely to have had previous residential placements and suffer from hyperactive, impulse and dysregulation disorders, sensory disorders, depression, anxiety, suicidality, and other psychopathologies.[11, 12] Circumstances leading to placement and placement itself can be traumatizing experiences. A goal of Senate Bill 14, passed in 2019, that will expand New Hampshire's system of community-based care is to minimize the need for residential treatment. Effective care in any setting requires an understanding of child development, effects of interrupted development, and effects of the interventions undertaken on their behalf, including the use of restraint and seclusion.

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[10] Purvis, KB, Cross, DR, Dansereau, DF & Parris, SR, (2013). *Supra note 3*.

[11] Connor, DF, Doerfler, LA, Toscano Jr., PF, Volungis, AM & Steingard, RJ, (2004). Characteristics of children and adolescents admitted to a residential treatment center. *Journal of Child and Family Studies*, 13(4): 497-510. DOI: 10.1023/B:JCFS.0000044730.66750.57

[12] Cohen, JA, Mannarino, AP, Jankowski, K, Rosenberg, S, Kodya, S, & Wolford II, GL, (2016). A randomized implementation study of trauma-focused cognitive behavioral therapy for adjudicated teens in residential facilities. *Child Maltreatment*, 21(2): 156-167. 156–167. doi:10.1177/1077559515624775.

Incident Narrative B. "Derek" Case documents reveal "Derek", a boy who was adjudicated delinquent and placed at a private residential facility, "typically becomes triggered before or after a court date." On this day he returned from court expressing frustration with the outcome, saying that "nobody hears him or appreciates how well he has done." When it was time to go to bed, he refused and sat on the floor in the hall for an hour. When prompted to go to his room, he attempted to leave and staff used body positioning to prevent him. Derek then again sat in the hallway. The staff gave him the option to enter his room or have it stripped. They began to strip his room. He went into the room within two minutes. A staff person followed him into the room and shut the door. The report states Derek was "upset that faculty were stripping his room" and tried to leave. The staff person used body positioning to prevent him from leaving and Derek punched him. A restraint followed that escalated with several staff and Derek taking aggressive physical actions.

Child Development and Risks of Interruption

Recent advancements in neuro-scientific technology have confirmed theories of phased cognitive, emotional and social development that explain how children grow physically, and acquire intellect, character, personality, temperament, social skills, and coping capacity.[13,14,15] Each part of the brain controls separate functions, including intellectual and social skills. Magnetic resonance imaging (MRI) demonstrate that each part of the brain, and therefore its associated skills, develops on different timelines. The entire brain is not fully developed until at least age 25.[16]

Primary brain functions develop first, including primitive survival functions of attachment, safety, self-regulation, and language functions. A child's capacity to learn language, to read and write, and form healthy relationships continues to develop into early adolescence. Around that time, there is an explosion of brain growth, particularly in the areas of insight and executive functioning (the ability to plan and problem solve). Development is also highly impacted by the child's environment (caregivers, school, community, social networks).[17] Perhaps most importantly child safety and attachment to caregiving adults are key factors in brain development and lifelong health.[18]

A number of factors influence or interrupt developmental gains. Congenital conditions or malformations from birth, exposure to toxic substances, injuries and infection may all affect a child's capacity to develop. Adverse childhood experiences, including poverty, violence, loss of a parent, exposure to

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[13] Institute of Medicine and National Research Council, (2000). *From Neurons to Neighborhoods: The Science of Early Childhood Development*. Washington, DC: The National Academies Press. Https://doi.org/10.17226/9824

[14] Piaget, J. (2007). *The Child's Conception of the World*. Lanham, MD: Rownam & Littlefield.

[15] Erikson, E. (1984) *The Lifecycle Completed*. WW Norton & Company.

[16] Arain, M, Haque, M, Johal, L, Mathur, P, Nel, W, et al., (2013). Maturation of the adolescent brain. *Neuropsychiatric Disease and Treatment*, 9: 449-461. doi: 10.2147/NDT.S39776

[17] Bronfenbrenner, U & Morris, PA, (2007), *The Bioecological Model of Human Development. Theoretical Models of Human Development*, Wiley & Sons Incorporated. doi/abs/10.1002/9780470147658.chpsy0114

[18] Donahue, P. J., Falk, B., & Provet, A. G. (2007). Promoting social-emotional development in young children: Mental health supports in early childhood environments. In D. F. Perry, R. K. Kaufmann, & J. Knitzer (Eds.), *Social and emotional health in early childhood: Building bridges between services and systems* (p. 281–312). Baltimore: Paul H Brookes Publishing.

substance use or mental illness, and exposure to trauma and interrupt brain development affecting social, emotional, cognitive, and behavioral development.[19]

The same MRI technology that confirmed brain growth over time has also captured loss of brain function upon exposure to adverse experiences.[20] The corresponding outcomes of those adverse experiences include the behaviors that commonly cause children to be placed in residential treatment facilities: anti-social, emotional and behavioral dysregulation, poor impulse control, substance misuse, early pregnancy, and lifelong health issues.[21,22] These behaviors are actually physiologically protective. But they are manifestations of an overstimulated protection system.

A part of the brain that responds to danger, the amygdala, may become locked in the fear response mode, with a lower threshold for activation.[23] This child perpetually feels unsafe, even if there is no apparent danger. This state may look like hypervigilance, hyperactivity, aggressiveness, or deep withdrawal. The associated behaviors with this state may be disruptive and even appear dangerous, prompting physical intervention. Incident Narrative B. demonstrates a conflict in a child's coping strategy that did not fit with the residential facility routine. "Derek" sat on the floor in violation of some rule about place or expected activity (going to bed).

"I don't feel safe around the staff who hurt me. They don't feel comfortable around me."

Child who was restrained

When the staff responded with stripping his room of personal possessions, a history of trauma may have triggered a fear response to that invasion of privacy, prompting him to attempt to flee. The staff blocking his way may have elevated distress of danger, which caused him to assault the staff. In this physiologically protective mode, a child's ability to trust may be threatened, interfering with ability to bond or develop a sense of belonging and social connection.[24] The child may not have the capacity to make protective decisions and manage emotional upsets.

Sensory disorders that interfere with capacity to control response to sensory input may also appear as problem behavior. They may seek out high intensity sensory simulation or avoid it in fear response. They may touch others too much or respond aggressively when touched.[25] He or she may not tolerate the fabric of facility-issued socks. In a rigid, institutional routine of a residential setting, either child will be at

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[19] Felitti, VJ, Anda, RF, Nordenberg, D, Williamson, DF, Spitz, AM, et al, (1998). Relationship of childhood abuse and household dysfunction to many of the leading cases of death in adults: The adverse childhood experiences (ACE) study, *American Journal of Preventive Medicine,* 14, (4):245-258. DOI: https://doi.org/10.1016/S0749-3797(98)00017-8

[20] Felitti, VJ, Anda, RF, Nordenberg, D, Williamson, DF, Spitz, AM, et al, (1998). *Supra note 19.*

[21] Institute of Medicine and National Research Council, (2000). *Supra note 13.*

[22] Perry, B. D. (2009). Examining child maltreatment through a neurodevelopmental lens: Clinical applications of the Neurosequential Model of Therapeutics (NMT). *Journal of Trauma and Loss, 14,* 1–16.;

[23] Institute of Medicine and National Research Council, (2000). *Supra note 13.*

[24] Gobin, RL & Freyd, JJ, (2014). The impact of betrayal trauma on the tendency to trust. Psychological Trauma: theory, Research, and Policy, 6(5): 505-511. http://dx.doi.org/10.1037/a0032452

[25] Mneot, SH Miller, LJ, McIntosh, DN, McGrath-Clarke, J, Simon, J, et al., (2001). Sensory modulation dysfunction in children with attention-deficit-hyperactivity disorder. *Developmental Medicine & Child Neurology*, 43: 399-406. https://onlinelibrary.wiley.com/doi/pdf/10.1111/j.1469-8749.2001.tb00228.x

risk for restraint or seclusion. Children also still have normal developmental needs, wishes and disappointments that may be expressed problematically in an institutional context.

Children view restraint or seclusion by professional caregivers as aversive, which eliminates any potential therapeutic effect.[26] Staff who may lack knowledge of these conditions, and even normal child comportment, will view problem behavior as willful non-compliance rather than a fear survival response and a manifestation of a condition or response to simple childhood disappointment. Incident Narrative A. is a case in point. "Josh" experienced a disappointment surrounding a high value childhood connection to his family through a personal memento. Loss of the personal memento could cause any child to brood. The loss and subsequently the aversive experience of restraint or seclusion conflict with trust building. In addition to the absence of evidence that restraint and seclusion is beneficial,[27] the use of these practices represent significant potential harm to a child's development as further exposure to adverse experiences. "[R]estraint and seclusion may cause, reinforce, and maintain aggression and violence."[28]

"[Seeing] *restraints would scare some kids … they would be scared of what would happen to the kids who were restrained.*"

Child describing witnessing restraint incidents

With the right treatment and supports, children can be remarkably resilient and re-gain lost abilities. Residential treatment settings that provide 24/7, all-staff engaged, consistent and supportive therapeutic milieu can promote healing and developmental gains. Effective treatment models emphasize trust building for effective outcomes. The framework of health outcomes from positive experiences (HOPE) promotes resilience through nurturing, supportive relationships; and an environment in which a child feels safe, supported and a sense of belonging rather than exclusion.[29]

Being Safe and Feeling Safe

For most traumatized children, problematic behavior patterns represent the fact that they see common demands as existential threats to their safety.[30] Whether a situation warrants or not, a child may experience the physiological equivalent of uncontrollable and constant fear. In addition to promoting healing relationships and coping skills for children with traumatic histories, perhaps the most important factor of care is ensuring safety.[31] The primary task of child protective services and even juvenile justice is also safety. The New Hampshire law governing the use of restraint and seclusion limits the use of restraints only to "ensure the immediate physical safety of persons."[32] In the case of seclusion, its use is limited to, "when a child's behavior poses a substantial and imminent risk of physical harm,"[33] - a

[26] Substance Abuse and Mental Health Services Administration, (2011). *Supra note 6, (p.3).*
[27] U.S. Department of Education (2012). *Restraint and Seclusion: Resource Document*. Washington, D.C. Accessed at https://www2.ed.gov/policy/seclusion/restraints-and-seclusion-resources.pdf.
[28] Substance Abuse and Mental Health Services Administration, (2011). *Supra note 6.*
[29] Sege, RD & Browne, CH, (2005). Responding to ACESs with HOPE: Health outcomes from positive experiences. *Academic Pediatrics* 17(7S): S79-S84. https://www.sciencedirect.com/science/article/pii/S1876285917301079
[30] van der Kolk, BA, (2005). Developmental trauma disorder: Toward a rational diagnosis for children with complex trauma histories. *Psychiatric Annals*, 35(5): 401-408.
[31] Purvis, KB, Cross, R, Dansereau, DF & Parris, SR, (2013). *Supra note 3.*
[32] RSA 126-U:5, I.
[33] RSA 126-U:5-a, I.

measurement of safety. Safety is the essence of State government involvement in a child's life. Yet the meaning of safety in each context varies substantially.

Most importantly, from a child's perspective, being safe and feeling safe are not the same. The fear of hunger, for example, will distract a child from learning. Although facility staff may be certain there will be plenty of food for the child, the child may not understand that. Treatment would need to reinforce, often with tangible evidence, that food is readily available.[34] Likewise, a child whose adverse experience involved physical abuse or emotional maltreatment may require careful and consistent reinforcement of safety from harm, regardless of exhibited behaviors. A physical restraint or a banishment to seclusion may serve to reinforce or re-awaken the fear of harm or rejection. Environments designed to promote safe and predictable relationships support trust building. In the safety of trust, children's responses to the world around them shift from fear-driven to trust-driven behavior.[35] Aiming to promote the feeling of safety will thus reduce problem, fear-based behaviors that prompt the use of restraint or seclusion.

Disproportionate Risk of Restraint

The practice of restraint falls disproportionately on certain groups. Children are more likely to be restrained than adults.[36] Children are more likely to die or be seriously injured as a result of restraint than adults.[37] Children of color are more likely to be restrained than white children.[38] Children with disabilities are more likely to experience restraint and seclusion than those without disabilities.[39] Institutionalized children, the focus of this report, pose greater levels of "functional impairment…often associated with a history of abuse and neglect, exposure to violence in the community, and multiple placement transitions and attachment disruptions" than children receiving services in nonresidential settings.[40] Institutionalized children, therefore, are at higher risk for traumatic experience and injury associated with restraint and seclusion, particularly if they are of racial/ethnic minority or have disabilities.

SYSTEM ISSUE UNDER REVIEW: RESTRAINT & SECLUSION

Incidence of Restraint & Seclusion

In the 5-year period 2014-2018, the department reported more than 20,000 incidents of child restraint and seclusion in residential treatment facilities and the SYSC. That included 15,544 restraint incidents and 4,980 seclusion incidents. By comparison, New Hampshire public schools reported 5,245 restraint incidents and 3,429 seclusion incidents from school years 2015 to 2018.[41] Pursuant to the OCA's limited

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[34] Purvis, KB, Cross, R, Dansereau, DF & Parris, SR, (2013). *Supra note 3.*

[35] Knight, DC, Smith, CN, Cheng, DT, Stein, EA, Helmstetter, FJ, (2004). Amygdala and hippocampal activity during acquisition and extinction of human fear and conditioning. *Cognitive, Affective, and Behavioral Neuroscience*, 4(3): 317-325. DOI:10.3758/cabn.4.3.317.

[36] Smith, ML, & Bowman, K. M. (2009). The restraint spiral: emergent themes in the perceptions of the physical restraint of juveniles. *Child Welfare*, 88(3).

[37] LeBel, J, et al. (2004). Child and adolescent inpatient restraint reduction: A state initiative to promote strength-based care. *Journal of the American Academy of Child & Adolescent Psychiatry*, 43(1), 37-45.

[38] Smith, ML, & Bowman, KM, (2009). *Supra note 36.*

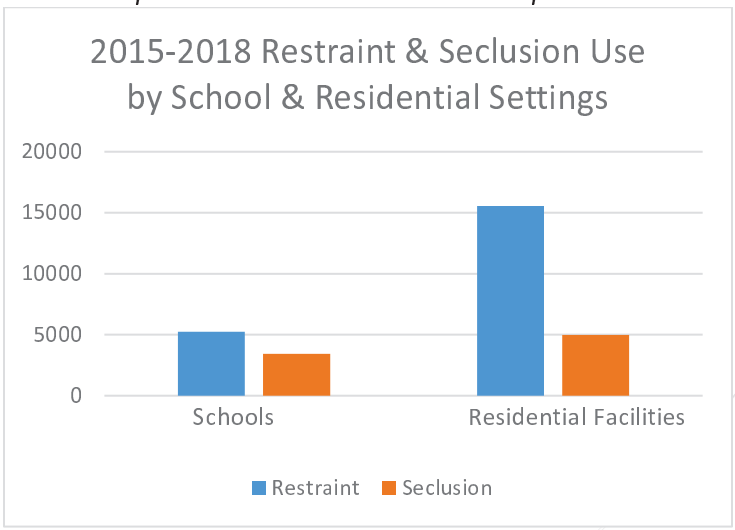
[39] Gagnon, DJ, Mattingly, MJ, & Connelly, VJ, (2013). Variation found in rates of restraint and seclusion among students with a disability. *Carsey Institute National Issue Brief 67.* Durham: University of New Carsey School of Public Policy.

[40] Roy, C., Castonguay, A., Fortin, M., et al. (2019). *Supra note 1.*

[41] New Hampshire Department of Education (2019). School Safety Data Collection. https://www.education.nh.gov/data/school-safety-data.htm. (2014 data not available)

jurisdiction to DCYF, this System Review Report focuses only on the use of restraint and seclusion of children DCYF places in residential facilities (See Figure 1.).[42]

Figure 1. School to DCYF-placed Restraint & Seclusion Comparison[43]



In addition to the SYSC the department reports were generated from a range of 23 to 24 residential treatment facilities. Distribution of incidents of restraint and seclusion was not equal across facilities. Each varied in the size and needs of populations served. Some providers claim use of restraint and seclusion will differ based upon those factors. Three providers reported over 2,000 restraint incidents from 2014 to 2018; they were Spaulding Youth Center (2,168 incidents), Crotched Mountain School (3,880 incidents), and Easter Seals Zachary Road (5,205 incidents). Each of those facilities described the populations of children served to include those with severe disabilities, aligning with findings that children with disabilities are most at risk of restraint or seclusion. Children with disabilities in New Hampshire residential treatment facilities experience developmental disorders, nonverbal learning disabilities, traumatic brain injuries, emotional disabilities, and other neurological disorders.

Reported incidents of seclusion in the 2014-2018 period were more varied than those of restraints. Institutions reporting the highest use of seclusion included Pine Haven Boys Center (442 incidents), Easter Seals Zachary Road[44] (667 incidents) and Spaulding Youth Center[45] (3,408 incidents). In 2018, one institution, Spaulding Youth Center, comprised nearly 89 percent of all seclusion incidents in the state. Only two of New Hampshire's residential treatment facilities, Pine Haven Boys Center and Spaulding Youth Center, and the state-run SYSC reported recent use of seclusion, although nine facilities reported use of seclusion at least once from 2010 to 2018.

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[42] Note: Restraint and seclusion data may include incidents involving children placed in facilities by authorities other than DCYF, including school districts. There is no way to disaggregate the data the OCA receives from DCYF. While the OCA may analyze the aggregate data, the Office has no authority to intervene in the interest of the children placed by other authorities. Senate Bill 295, introduced in the 2018-19 legislative session by Senator Sharon Carson, proposes expanding the OCA's jurisdiction to provide oversight for child safety across all state-supported services.

[43] New Hampshire Department of Education (2019). School Safety Data Collection and DHHS Annual Reports.

[44] As of November 2016, Easter Seals Zachary Road reports no longer using seclusion.

[45] As of December 1, 2019, Spaulding Youth Center reports they are working to be seclusion-free.

Thoroughly describing the incidence of restraint of children is complicated by a history of definition adjustment and fluid reporting mandates. Until 2014, the definition of restraint as "bodily physical restriction, mechanical devices, or any device that unreasonably limits freedom of movement" was interpreted to exclude "brief" or "reasonable" physical restraints. Consequently, almost no reports of restraining institutionalized children were made, with only 153 reported restraint incidents from 2010 to 2014. Restraint reports sharply increased in October 2014 across the majority of institutions after new, more stringent requirements were passed.[46] There were 5,123 incidents within a single year after the new requirements were implemented, marking a 3,248 percent change from the previous five years. The fluctuations of reporting requirements and definitions may affect accuracy of reporting. Some facilities reported difficulty interpreting guidelines about what constitutes an individual restraint incident. For example, if an incident with a child lasts forty-five minutes and involves six separate holds, one facility may record that as only one overall incident of restraint while another facility may log it as six separate incidents. Disparate reporting practices at different institutions prevent effective comparison of data and understanding of the degree to which the practices are employed.

Restrictions of restraint and seclusion use and corresponding reporting mandates exist because of a history of policy and practice debate. A brief review of that history demonstrates the need for oversight and protection of children in institutional settings and the importance of reporting events.

National Perspective of Restraint & Seclusion

In 1998 a series of articles published by *The Hartford Courant* exposed a pattern of serious injuries and deaths resulting from restraints across the country that set the stage for debate and policy change.[47] Several federal investigations followed by the U.S. General Accountability Office (GAO) in 1999, 2009 and 2019; and the U.S. Senate Health, Education, Labor, and Pensions Committee in 2014. Each investigation and subsequent report identified severe injuries and deaths resulting from the use of restraint and seclusion in schools and treatment centers and a patchwork of unclear state laws governing the practice. The resulting reports all called for limiting use of restraint and seclusion to specific circumstances, comprehensive reporting when the measures were used, and staff training on alternative approaches to crisis management.[48, 49, 50, 51] A more recent 2019 GAO report questioned the quality of restraint and seclusion data the U.S. Department of Education was collecting from individual

[46] RSA 126-U. Updated version (with changes) http://gencourt.state.nh.us/legislation/2014/SB0396.html.
[47] Weiss, EM, Altimari, D, Blint, DF, et al, (198). Deadly restraint: A Hartford Courant investigative report. *Hartford Courant*, October 15, 1998.
[48] U.S. Senate Health, Education, Labor, and Pensions Committee (2014). *Dangerous Use of Seclusion and Restraints in Schools Remains Widespread and Difficult to Remedy: A Review of Ten Cases*. Washington, D.C. https://www.help.senate.gov/imo/media/doc/Seclusion%20and%20Restraints%20Final%20Report.pdf .
[49] U.S. Government Accountability Office (2009). *Selected Cases of Death and Abuse at Public and Private Schools and Treatment Centers.* Washington, D.C. https://www.gao.gov/new.items/d09719t.pdf?mod=article_inline.
[50] U.S. Government Accountability Office (2009), *Supra note 49.*
[51] U.S. General Accountability Office (1999). *Improper Restraint or Seclusion Use Places People at Risk*. Washington, D.C. https://www.gao.gov/archive/1999/he99176.pdf.

school districts. According to the GAO, a significant number of school districts underreported or misreported the number of restraint and seclusion incidents in the 2015-16 school year.[52]

Scrutiny and Policy Change in New Hampshire

In 2009, 2010, and 2018 the Disability Rights Center—NH (DRC), the federal protection and advocacy agency for people with disabilities, investigated incidents of restraint and seclusion at SYSC. The DRC is empowered by federal law "to pursue legal, administrative and other appropriate remedies" on behalf of people with disabilities.[53] First, in 2009 examining the restraint of an individual boy, and later in 2010 examining system-wide operations, the DRC consistently observed the use of "unnecessary and excessive force" on a child,[54] "a culture of the use of force to control residents,"[55] and "issues regarding SYSC's reporting and review processes.[56] The DRC reports, along with the national dialogue on the dangers of restraint and seclusion, prompted New Hampshire to take legislative action in 2010 by creating law governing child restraint and seclusion in RSA Chapter 126-U. Through the law, legislators banned certain dangerous restraint techniques and required that any use of restraint or seclusion in a school or treatment facility be reported to a parent or guardian within 24 hours, among other things.[57]

Prone Restraints

In the 1998 *Hartford Courant* nationwide series delving into cases of people dying from restraint use in mental health treatment facilities, the majority of deaths involved children. Twenty-three of the deaths resulted from "face-down floor holds," many of which "could have been prevented by…the banning of dangerous techniques such as face-down floor holds."[58] A systematic review of a sample of 45 child and adolescent fatalities related to restraints in residential facilities found that over half of the deaths resulted from a prone restraint.[59] Despite the findings in the national investigations, deliberations on restraint and seclusion law in New Hampshire were most contentious on the issue of prone restraint.

The Joint Commission on the Accreditation of Healthcare Organizations (Joint Commission) opines that restraining patients in the prone position may "predispose them to suffocation."[60] In an extensive

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[52] U.S. Government Accountability Office (2019*). K-12 Education: Education Should Take Immediate Action to Address Inaccuracies in Federal Restraint and Seclusion Data*. Washington, D.C. https://www.gao.gov/assets/700/699795.pdf.

[53] 42 U.S.C. § 143(a)(2)(A)(i). Accessed at https://www.acf.hhs.gov/sites/default/files/add/dd_act.pdf.

[54] Cohen, R. and Whitley, R. (2009). Initial Investigation Report, Findings & Recommendations on Allegation of Use-of-Force and Mechanical Restraint Against Detained Youth at the John H. Sununu Youth Services Center on June 9, 2008. Accessed at https://drcnh.org/wp-content/uploads/2019/01/SYSC_Report_Jan_2009.pdf.

[55] Cohen, R. and Whitely, R. (2010). Investigation Report, Findings & Recommendations, The Use of Force and Restraint and Adequacy of Mental Health Care at the John H Sununu Youth Services Center (October 5, 2010). Accessed at https://drcnh.org/wp-content/uploads/2019/01/SYSC_Report_2_Oct_2010.pdf.

[56] *Id*.

[57] RSA 126-U:4, :7

[58] Weiss, E.M. (1998). Hundreds of the Nation's Most Vulnerable Have Been Killed by the System Intended to Care for Them. *The Hartford Courant*.

[59] Nunno, M. A., Holden, M. J., & Tollar, A. (2006). Learning from tragedy: A survey of child and adolescent restraint fatalities. *Child Abuse & Neglect*, 30(12), 1333-1342.

[60] Mohr, WK, Petti, TA, & Mohr, BD (2003). Adverse Effects Associated with Physical Restraint. *The Canadian Journal of Psychiatry*, 48(5), 330–337, (p.332).

review of the literature, "death from positional asphyxia was found to occur when individuals were placed in a position that did not allow adequate breathing, most often a prone position."[61]

The attention to dangerous outcomes of restraints, combined with advances in behavioral science for better, preventive treatment, has prompted other states to adopt laws prohibiting or limiting the use of prone restraints. Table 1. summarizes regional differences in the legality of prone restraints.

> ***"[T]here is measurable impairment of respiratory function"***
>
> *New Hampshire Medical Examiner*
> *Thomas Andrew, MD 2010*

Anatomically, prone position impairs breathing and increases a child's risk of asphyxiation, cardiac arrest, and death.[62] Then-Chief Medical Examiner Dr. Thomas Andrew testified before the New Hampshire Senate Health and Human Services Committee describing the physiology of prone positioning, explaining, "Both muscular aspects of ventilation are impaired" in a prone restraint, and "there's a measurable and significant difference of that impairment if weight is placed on the person's back," which causes compression of the chest.[63] Even without added weight of another person involved in restraining, "there is measurable impairment of respiratory function" due to the risk of asphyxia and sudden cardiac arrhythmias.[64]

Ultimately, RSA 126-U:4, with its prohibition of restraint techniques that interfere with normal breathing, has the effect of banning the prone restraint of children in New Hampshire. Under paragraph I of that section,

> No school or facility shall use or threaten to use . . . [a]ny physical restraint or containment technique that:
> (a) Obstructs a child's respiratory airway or impairs the child's breathing or respiratory capacity or restricts the movement required for normal breathing;
> (b) Places pressure or weight on, or causes the compression of, the chest, lungs, sternum, diaphragm, back, or abdomen of a child;
> (c) Obstructs the circulation of blood;
> (d) Involves pushing on or into the child's mouth, nose, eyes, or any part of the face or involves covering the face or body with anything, including soft objects such as pillows, blankets, or washcloths; or
> (e) Endangers a child's life or significantly exacerbates a child's medical condition.

Although the word "prone" is not specifically used in the statute, its language clearly addresses the dangerous physiological positioning and consequences of prone restraint, and by doing so effectively

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[61] Mohr, W. K., Petti, TA, & Mohr, BD, *Supra note 60.*
[62] Disability Rights California (2002). *The Lethal Hazard of Prone Restraint: Positional Asphyxia*. https://www.disabilityrightsca.org/system/files/file-attachments/701801.pdf.
[63] Andrew, Thomas, New Hampshire Chief Medical Examiner (2010). Statement before the New Hampshire Senate Committee on Health & Human Services. *Hearing on SB 396-FN, Feb. 9, 2010.*. http://gencourt.state.nh.us/SofS_Archives/2010/senate/SB396S.pdf.
[64] Andrew, Thomas, New Hampshire Chief Medical Examiner (2010). *Supra note 63.*

Table 1. Regional State Prohibitions on Prone Restraints

STATE	RESIDENTIAL TREATMENT FACILITIES	SCHOOLS
Connecticut[65]	"Any physical restraint or hold of a person that restricts the flow of air into a person's lungs, whether by chest compression or any other means"	Prone Restraints
Maine[66,67]	Prone restraints prohibited	Restraint "that restricts the free movement of the diaphragm or chest or that restricts the airway so as to interrupt normal breathing or speech (restraint-related positional asphyxia) of a student"
Massachusetts[68]	"[P]rone restraints prohibited. Exception on individual bases, if all 6 conditions met": documented history, alternatives failed, no medical contraindications, documented psychological justification, written consent for emergency use to prevent serious injury, must be in "position that allows airway access and does not compromise respiration."	"[P]rone restraints prohibited. Exception on individual bases, if all 6 conditions met": documented history, alternatives failed, no medical contraindications, documented psychological justification, written consent for emergency use to prevent serious injury
New Hampshire[69]	"[A]ny restraint that "[o]bstructs a child's respiratory airway or impairs the child's breathing or respiratory capacity or restricts the movement required for normal breathing…[p]laces pressure or weight on, or causes the compression of, the chest, lungs, sternum, diaphragm, back, or abdomen of a child" or "[o]bstructs the circulation of blood,"	"[A]ny restraint that "[o]bstructs a child's respiratory airway or impairs the child's breathing or respiratory capacity or restricts the movement required for normal breathing…[p]laces pressure or weight on, or causes the compression of, the chest, lungs, sternum, diaphragm, back, or abdomen of a child" or "[o]bstructs the circulation of blood,"
New York[70]	Prone restraints prohibited	No prohibition
Rhode Island[71]	Prone restraints prohibited	Prone restraints prohibited
Vermont[72]	"Restraints that impede a child/youth's ability to breathe or communicate"	Prone restraints when less restrictive restraints fail or are ineffective

[65] Conn. Gen. Stat. ch. 814e § 46a-150-4. https://www.cga.ct.gov/current/pub/chap_814e.htm.
[66] 10-144 Me. Code R. 36 § 5.O(5). https://www.maine.gov/sos/cec/rules/10/chaps10.htm.
[67] 05-071 Me. Code R. 33 § 6.2(A). https://www.maine.gov/doe/schools/safeschools/restraint.
[68] MA 603 CMR 46.03(1)(b) and 606 CMR 3.07(7)(j)(15), 3.07(7)(j)(1)(b).
[69] NH RSA chapter 126-U:4
[70] The Laws of New York, Consolidated Laws Article 31.19
[71] R.I. Gen Laws § 42-158-3. http://webserver.rilin.state.ri.us/Statutes/TITLE42/42-158/42-158-3.HTM.
[72] Vt. Code R. 13 172 001-648. https://bit.ly/31AFvhz.

prohibits it. In addition, the legislative history, including Dr. Andrew's testimony, as well as the medical literature, evinces the intent to prohibit prone in virtually all circumstances. However, the use of prone restraints by some facilities suggests either a refusal to comply with the law or different interpretations in terms of its use and the department's oversight.

The Department Addresses Prone Restraints

In 2019, the department issued an undated letter to all residential treatment facilities stating, "The Department *recommends* against the use of prone restraints and we *encourage* you to update your policies and procedures accordingly (emphasis added)."[73] Similarly, SYSC Policy 2083 states that "[y]outh in restraint shall not be left in a prone position due to the possibility of positional asphyxia," which is defined as "when the position of a person's body cuts off or interferes with their breathing that leads to hypoxia, an inadequate amount of oxygen to meet the body's demand."[74]

Unfortunately, the department's practices and communications, its formal guidance to providers, and the SYSC restraint policy have been inconsistent with regard to the use of prone restraint. In July 2019, the department surveyed residential providers as to whether they train for and use prone restraint.[75] Of 29 residential facilities responding, four reported continued use of prone restraint. SYSC was not surveyed, but prone restraints continue to be used at the facility.

The DRC's third report on the topic of restraint and seclusion, released in 2018, addressed a December 2016 incident in which a fourteen-year-old boy at SYSC suffered a fractured scapula after being forced into a prone restraint. Their report concluded that SYSC "routinely" uses prone, face-down restraints in opposition to their own policy.[76] The department commissioner and the New Hampshire Department of Justice (DOJ), the agency responsible for leading investigations of abuse or neglect in state-owned institutions under RSA chapter 126-U, disputed the DRC's findings, claiming "[t]hese limited examples cannot support a conclusion that this is a 'routinely' or 'regularly' implemented action under any definition."[77]

A review of reports in the SYSC database found that, of the 43 restraint incidents reported to the OCA since August 2018, at least 20 incidents involved staff members placing children in a prone restraint. Children were further restricted with handcuffs in 10 of the 20 reported incidents of prone restraints. Inconsistencies in completing incident reports is another factor in determining the extent of use. In one incident report from the SYSC, a staff account clearly described a prone restraint, but prone restraint was not checked in the report section regarding restrictive intervention and restraint techniques.

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[73] New Hampshire Department of Health and Human Services, Division for Children, Youth and Families (2019). 2019 *Notice Regarding the Use of Prone Restraints*.

[74] Sununu Youth Services Center (2016). *SYSC Policy 2083 Restraint*. https://www.dhhs.nh.gov/dcyf/documents/dcyfpolicy2083.pdf.

[75] July 24, 2019 department communication to all residential facilities.

[76] Disability Rights Center –NH (2018). Unlawful Use of Physical Restraint at Sununu Youth Services Center Manchester, NH. Concord: Disability Rights Center - NH

[77] New Hampshire Office of the Attorney General (2018). Re: *DCYF'S Response to The Disability Rights Center's May 8, 2018 Report Regarding Unlawful Use Of Physical Restraint At The Sununu Youth Services Center*. Concord: New Hampshire Department of Justice and Department of Health and Human Services.

Following the department's July 2019 provider survey, the OCA inquired what action was planned for addressing the providers who continue to employ prone restraints on children. A department staff responded, stating that providers are using proven safe methods of prone restraints, suggesting, so long as training is undertaken, they are safe restraints. The department reported to the OCA that some providers pushed back on the encouragement to abandon the use of prone restraints, suggesting the department was exceeding the requirements of the law, already addressed in the legislative dialogue. This refers to the extensive discussions legislators, advocates, medical experts and agency personnel when the prohibitions in RSA 126-U:4, I were under consideration during the legislative process.

The department stopped short of insisting providers comply with the law that prohibits the use of restraints that, in effect, translate to prone restraints. Still, even their recommendation against the use of prone restraints was inconsistent with their own practice in the department-run SYSC. These inconsistencies create the risk of the continued use of a known, potentially lethal, and empirically proven ineffective practice.

The debate about the legality of prone restraints serves only to distract from the fact that prone restraints have been definitively determined to be dangerous and dehumanizing. The department, as the agency of child protection, public health, and developmental health, has an obligation to ensure children are safe, feel safe, and are able to access appropriate, effective care. To that end, rather than recommend against the use of prone restraint, one remedy would be to prohibit its use in the contract process. It has been six years since the last adjustment of RSA 126-U and still there is disagreement about whether prone restraint is prohibited. If the department cannot influence safe care of children through contract, it will be necessary to acknowledge the ineffectiveness of the law.

During the fall the writer of this report received minor injuries to the forehead and to the back of the hands.
Staff report of restraint incident

Weighing Risk vs. Benefits of Restraint & Seclusion Use

The process of child development and conditions that may manifest from interruptions of development described above, situate children for negative effects of restraint and seclusion. In addition to physical injury, experiencing restraint or seclusion can have serious adverse psychological effects.[78] Being restrained or secluded may also trigger re-traumatization for children who have experienced prior physical or sexual abuse or other forms of trauma. Restraint and seclusion can contribute to setbacks in children's response to treatment,[79] extend length of stay, and predict readmissions.[80] In addition to the predictable negative effects, "There is no evidence that using restraint or seclusion is effective in reducing the occurrence of the problem behaviors that frequently precipitate the use of such techniques."[81] The practice of seclusion has little to no therapeutic benefit and may cause additional

[78] Mohr, WK, Petti, TA, & Mohr, BD (2003). *Supra note 60.*
[79] Massachusetts Department of Mental Health Task Force, & Carmen, E. (1996). *Task Force on the Restraint and Seclusion of Persons Who Have Been Physically or Sexually Abused: Report and Recommendations*. https://archive.org/details/reportrecommenda00mass_0.
[80] Substance Abuse and Mental Health Services Administration, (2011). *Supra note 6*.
[81] U.S. Department of Education (2012). *Restraint and Seclusion: Resource Document*. Washington, D.C. Accessed at https://www2.ed.gov/policy/seclusion/restraints-and-seclusion-resources.pdf.

trauma and harm.[82] The use of restraint and seclusion is not just harmful to children who are on the receiving end of these interventions, but also to the staff who administer them and the programs themselves. The effects of restraint and seclusion are far-reaching.

Restraint & Seclusion as Human Error

In 2011 the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) examined the business implications of restraint and seclusion use.[83] SAMSHA described restraint and seclusion as "coercive, high-risk containment procedures used…to control maladaptive behaviors," with, "…not only physical and emotional risks but also the economic burdens inherent in their use."[84] Most notably, restraint and seclusion use is always proximal to conflict and often results in violence. Staff members may suffer physical injuries, psychological harm, and death in the use of restraints.[85] Considerable lost work time and medical costs result from acquired injuries and exposure to violence. The SAMHSA report echoes the potential negative effect of restraint and seclusion on children but beyond the immediate and prime concerns for children, outline additional other costs to the system that may ultimately limit the State's ability to assist children in need.

Workforce implications in the use of restraint and seclusion include burnout, turnover, and other disruptions of stable staffing through difficulties in recruitment, retention, productivity and efficiency.[86] Liability costs may also be prohibitive. Insurance underwriters routinely consider a facility's use of restraint and seclusion for potential financial risk in the form of workmen's compensation claims, injury-related medical costs, lost work hours, and litigation.[87] Individual facilities may see policy premiums rise. Although not directly referencing the use of restraint and seclusion, providers have shared concerns with the OCA about limited options of liability coverage in New Hampshire, without which they could not operate. Industry-wide risk is thus a consideration in determining the value of investment in restraint and seclusion reduction.

In 2000 the Institute of Medicine (IOM) issued a pivotal report exposing human error implicated in up to 98,000 deaths per year in healthcare.[88] Human error has since been a focus of healthcare reform. In mental and behavioral health, accuracy of diagnosis and treatment is complicated by obstacles including limited access to experts and reliance on minimally trained providers, time constraints, competing systemic demands, inconsistent access to medication, and inconsistent use of a systematic diagnostic interview.[89] Diagnostic error and insufficient treatment of mental health conditions or sensory disorders,

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[82] Finke, L. M. (2001). The use of seclusion is not evidence-based practice. *Journal of Child and Adolescent Psychiatric Nursing*, 14(4), 186-90.
[83] Substance Abuse and Mental Health Services Administration, (2011). *Supra note 6*.
[84] Substance Abuse and Mental Health Services Administration, (2011). *Supra note 6*, (p.5).
[85] U.S. Department of Health and Human Services (2010). *Promoting Alternatives to the Use of Seclusion and Restraint Issue Brief #1: A National Strategy to Prevent Seclusion and Restraint in Behavioral Health Services*. https://www.samhsa.gov/sites/default/files/topics/trauma_and_violence/seclusion-restraints-1.pdf.
[86] Substance Abuse and Mental Health Services Administration, (2011), *Supra note 6*.
[87] Substance Abuse and Mental Health Services Administration, (2011), *Supra note 6*.
[88] Institute of Medicine. 2000. Briefing. *To Err Is Human: Building a Safer Health System*. Washington, DC: The National Academies Press. http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/1999/To-Err-is-Human/To%20Err%20is%20Human%201999%20%20report%20brief.pdf.
[89] Medscape, (2007). Medication errors and patient safety in mental health. Medscape Psychiatry © Medscape CME & Education at https://www.medscape.org/viewarticle/563039

may result in aggressive, self-harming, or other problem behaviors that prompt the use of restraint or seclusion. Through this lens, and given the known negative impact of restraint and seclusion, including risk of injury, the need for restraint and seclusion is viewed as a "preventable adverse event."[90] Viewing restraint and seclusion as preventable adverse events is significant to health care payment structures.

Since 2008 the federal Centers for Medicare and Medicaid Services (CMS) stopped reimbursing hospitals for treatment required as a consequence of errors or preventable adverse events including outcomes associated with restraint and seclusion.[91] This might include the cost of surgery to repair a broken bone resulting from a physical restraint.[92] Loss of reimbursement is seen as an incentive for quality of care, in this case, restraint-free facilities. It is not clear whether other states are applying restrictions of reimbursement to residential treatment facilities, but it could be considered since, in New Hampshire the majority of admissions are covered by Medicaid. The risk of such a policy shift however, in a system with problematic reporting processes, is that incidents and injuries might not be reported and therefore left untreated. Until a more robust system is in place for reporting and surveillance, restricting reimbursement for preventable adverse events could worsen the situation for institutionalized children.

Whether or not New Hampshire considers reimbursement incentives for promoting restraint and seclusion-free facilities, it is still instructive to consider how such incentives have impacted acute and long term settings. More and more hospitals and long term care facilities for persons who are elderly or disabled are achieving restraint-free goals. In whatever way New Hampshire achieves restraint-free residential treatment, the staff will benefit. A U.S. Department of Health and Human Services study of a residential treatment facility for children in Virginia that instituted a policy aimed at eliminating restraint use found that resident-related staff injuries decreased by 41 percent after the change was implemented.[93] Other institutions that eliminated or significantly reduced the use of restraint reported decreased staff injuries and turnover, increased staff satisfaction, and cost savings.[94] Enhanced and consistent staff training decreases the use of restraint and seclusion and subsequently, resident and staff injury.[95] Quality care that serves children best, also serves staff, organizations and the state system itself.

RSA CHAPTER 126-U AND THE IMPORTANCE OF REPORTING

RSA Chapter 126-U

RSA Chapter 126-U:7 currently mandates that all schools and residential treatment facilities under the purview of the state collect information surrounding an incident of restraint or seclusion including, among other requirements:

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[90] Medscape, (2007). *Supra note 89.*

[91] Substance Abuse and Mental Health Services Administration, (2011), *Supra note 6*.

[92] CMS.gov (July 31, 2008). Medicare and Medicaid move aggressively to encourage greater patient safety in hospitals and reduce never events. Centers for Medicare & Medicaid Services at https://www.cms.gov/newsroom/press-releases/medicare-and-medicaid-move-aggressively-encourage-greater-patient-safety-hospitals-and-reduce-never

[93] U.S. Department of Health and Human Services (2010). *Promoting Alternatives to the Use of Seclusion and Restraint Issue Brief #4: Making the Business Case*. At https://www.samhsa.gov/sites/default/files/topics/trauma_and_violence/seclusion-restraints-4.pdf.

[94] U.S. Department of Health and Human Services (2010)., *supra* note 85.

[95] Busch, AB, & Shore, MF, (2000). Seclusion and restraint: A review of recent literature. *Harvard Review of Psychiatry*, 8(5), 261-270.

- The date, time, and duration of the use of seclusion or restraint
- A description of the actions of the child before, during, and after the occurrence
- The justification for initiating the use of restraint
- The names of the persons involved in the occurrence
- Any interventions used prior to the use of the seclusion or restraint
- Actions taken to address the emotional needs of the child during and following the incident
- Future actions to be taken to control the child's problem behaviors

According to RSA 126-U:7, III, facilities must maintain these records for review by the department. Revisions to the law in 2014 tightened reporting and required notification to parents or guardians no later than the time of the return of the child to the daily routine, if in a school setting, or by the end of the business day, whichever is earlier.[96] These changes also set stricter guidelines for the use of seclusion and closed a loophole allowing "brief periods of physical restriction" be exempt from reporting.[97,98] However, a number of gaps in the law persist.

Although required to collect detailed incident data, a gap in the law relieves facilities of reporting immediately to the department unless use of restraint or seclusion result in serious injury or death.[99] Until December 12, 2019, the majority of incidents were only reported to the department in monthly "tallies"[100] and in the annual aggregate report, devoid of context and meaning. DCYF caseworkers and JPPOs may receive individual reports from facilities, but it is not clear whether or how those reports are monitored or reviewed beyond being placed in the child's individual case file. RSA 126-U:9, II mandates the department conduct periodic, regular reviews of facility records on restraints and seclusions, including "the number and location of reported incidents and the status of any outstanding investigations," and submit an annual report to the legislature. Although some important information and trends can be gleaned from aggregate reports, the data is rough and basic. Raw numbers cannot communicate the nuances of an incident that might be illuminated with the details facilities are mandated to record under RSA 126-U:7, II. For example, of 100 restraint incidents, did they involve 100 children or one? Did they involve 100 staff persons or the same staff? Did they involve trends in antecedent behavior or inconsistent treatment protocols?

[96] RSA 126-U:7, IV

[97] S.B. 396 revised sections of RSA 126-U. Accessed at http://gencourt.state.nh.us/legislation/2014/SB0396.html.

[98] Bookman, T. (2014). Loophole Means Many Child Restraints Go Unreported In New Hampshire. *New Hampshire Public Radio*. Accessed at https://www.nhpr.org/post/loophole-means-many-child-restraints-go-unreported-new-hampshire.

[99] RSA 126-U:10, I.

[100] In two years of requesting incident reports the OCA has never received a monthly tally of restraints and seclusion in private residential facilities from the department.

Incident Narrative C. in which a debriefing revealed a child with problem behavior had not been administered prescribed medication, demonstrates the value of detail and report monitoring. A review of the report of "Liam's" restraint incident revealed an opportunity for restraint prevention through addressing medication administration processes. Over time, identification of a pattern of interrupted medication administration might signal the need for change in procedure and/or oversight. Without reporting, there is no ability for the agency to see over time whether facilities are developing useful prevention programs or changing a child's capacity to internalize healthy behavior to reduce the need for restraint or seclusion. This type of information informs areas for learning and system improvements. It would be equally useful to show improved outcomes as the system adjusts practice and quality of care.

Incident Narrative C.
"Liam"

Liam was upset about schoolwork in his private residential treatment school. He threw a pen at another child when leaving a room. In the hallway, he kicked and punched the walls. Staff members redirected Liam, attempting to calm him. In a quiet area, he was able to talk with a staff member. However, when Liam returned to the classroom to speak with the teacher, he became escalated. Liam flipped over a desk and chair and ran out of the room towards the exit. Staff members physically blocked Liam from leaving the building and got him to walk back to the quiet area. When there, Liam started shoving and spitting at staff members, who used proximity and deflection while encouraging Liam to talk. Liam's elevated behavior continued and he was placed in a TCI-approved supine physical management (restrained on his back on the floor) for safety. After 16 minutes of being held to the floor, Liam agreed to be safe and was released.

During the facility staff incident debriefing, it was discovered that Liam had not received his morning medications, an identified contributing factor to his aggressive behavior.

In response to two years of OCA requests to receive incident reports in compliance with RSA 170-G:18, the department notified the OCA on December 12, 2019, that a system was tentatively in place and reports would be forwarded to the OCA. An administrator described a process in which an E-mail "drop box" is now serving as a repository for residential facility reports of incidents, including restraints and seclusion. A department staff will collect data from each of the reports for storage in an Excel spreadsheet.

On December 27, 2019 the OCA received several documents of communications between the department and residential providers regarding new reporting. In a letter dated November 18, 2019, the department informed residential providers that in addition to reporting RSA 126-U:10 serious injuries or deaths from restraints and seclusions, "… we have been discussing with providers the plan to request, monitor and maintain data around other incidents which are happening in residential treatment programs. In the future we are going to be asking that significant incidents (as described below) be provided to the central email box (below)." Reports requested, the department explained, should be on all children who are:

- Placed by DCYF,
- Involved in an open case with DCYF,
- Involved in a current open assessment with DCYF
- Subject of an open special investigation by DCYF

There is no request for reports of children placed by other jurisdictions in New Hampshire, which suggests lack of child protection for some children living in New Hampshire in state-certified facilities. The types of incident reports requested include those of:

- Restraint and seclusions
- RSA 126-U:10 cases involving serious injury or death related to restraint or seclusion
- Suicide attempts
- Serious injury not related to restraint or seclusion

The department also furnished residential providers with "two guides for reporting that you may use should you choose to," but insisted the guides, "should not be interpreted as required or a form that must accompany a report." The Incident Reporting Checklist includes considerations for determining types of incidents and how they should be reported to DCYF (see appendix A and B). Giving providers the choice to use the DCYF forms rather than mandating their use predicts inconsistent data collection, complicating data analysis. The choice-giving also reflects the absence of a statutory mandate, or a contract, to report anything other than serious injury and death.

Despite the considerable delay, the department appears to be making progress towards monitoring the use of restraints and seclusion on children placed in residential treatment facilities in New Hampshire. Until December 2019, the lack of an infrastructure and process for managing and analyzing restraint and seclusion data at the department severely limited oversight of children placed out of sight of the usual child safety nets, including parental care. Prior to December 12, 2019, the OCA received only 69 reports of restraint or seclusion, 43 of them from SYSC. Over the course of nearly two years, 69 reports represented a fraction of incidents reported in one month on the most recent annual aggregate report. It should be noted there is no history of, nor does the new reporting process include, reporting of New Hampshire children being restrained or secluded while placed in residential treatment facilities out-of-state.

Rules of Oversight

The crafters of legislation governing the limited use of restraints and seclusion in New Hampshire foresaw a need for proactive oversight and quality assurance of the practice beyond data collection and an annual report. RSA 126-U:9, I, updated in 2014, mandates the "commissioner of the department of health and human services shall adopt rules…relative to…[p]eriodic, regular review by the department of health and human services of records maintained by facilities regarding the use of seclusion and restraint" in addition to "[a] process for the department's receipt of complaints and its conduct of investigations of reports of improper use of seclusion and restraint in facilities, which may be through the department of health and human services, office of the ombudsman, or otherwise." As of December 2019, the department has not adopted specific rules in accordance with this provision.

In its 2011 annual aggregate report to the House Children and Family Law Committee, the department reported they had commenced rulemaking with a public hearing, and receipt of comments from the DRC and the Office of Legislative Services – Administrative Rules. Received comments prompted the department to forego rulemaking. Writing that the record review and a process for complaints and investigations was already current practice, the department determined the rulemaking mandated by RSA chapter 126-U was unnecessary. Currently the department claims requirements of RSA 126-U are incorporated into "each individual rule set relative to the facilities to be monitored as required under

126-U."[101] This means there is no single, coherent set of rules implementing RSA 126-U:9's mandates for the department, including:

- A review of facility records regarding the use of restraint and seclusion
- A system in which to receive complaints and investigations of potential violations of RSA chapter 126-U
- The protection of children during and after investigations
- Remedial measures to address injury and reduce further violations of the law

Instead, a department official explained, regulations addressing RSA chapter 126-U are incorporated within existing administrative laws relating to individual agencies, such as the Child Care Licensing rules in He-C 4001. These address compliance with RSA chapter 126-U within the larger rule pertaining to Residential Child Care, but do not mention the requirements of RSA chapter 126-U:9, which are designed to ensure the department's own compliance with the law and protection of children by establishing a system for review. That would include conducting thorough and periodic reviews of restraint and seclusion practices at institutions under its purview.[102] Review might involve random auditing of records, inspecting individual incident reports, or physically observing facility routine to ensure restraint and seclusion practices meet legal standards. Rules expanding on review procedures would be a means to hold facilities accountable for their practices and enhance the safety and wellbeing of children placed by the State. They could also resolve the lingering confusion about how to define restraint and seclusion incidents, and formalize the reporting process recently initiated for consistency. It would also be a means to hold the department itself accountable for consistency and transparency of operations in ensuring children are safe and properly cared for.

Subsequent communications with the department in September 2019 revealed efforts underway to create an overarching rule to more clearly comport with their statutory responsibilities under RSA 126-U:9 and "create consistent expectations for each regulated facility and allow the Department to manage one rule for any updates and changes." This updated rule structure will "apply to all facilities."[103] As of December 2019, the OCA has not been informed of any updates on the status of rule adoption and has no information about whether the rules will include, as mandated, the department's responsibilities for oversight.

Furthermore, RSA 126-U:9, II mandates that the department "provide an annual report to the committees of the house of representatives and the senate with jurisdiction over health and human services and over children and family law, regarding the use of seclusion and restraint in facilities." This report "shall be based on the periodic, regular review of such records and shall include the number and location of reported incidents and the status of any outstanding investigations."[104] The language in RSA 126-U:9, II, therefore, requires the department to review restraint and seclusion incident reports from facilities and publish an annual report based upon that review. Any such review would also provide an important opportunity for the department to provide oversight regarding the proper use of restraint. The department reported to the OCA periodic reviews of restraint and seclusion practices and data collection as part of the two-year recertification process. They acknowledged, however, that there is no

[101] Personal communication 9/6/2019
[102] RSA 126-U:9, I(b)
[103] Personal communication 9/10/2019
[104] RSA 126-U:9, II

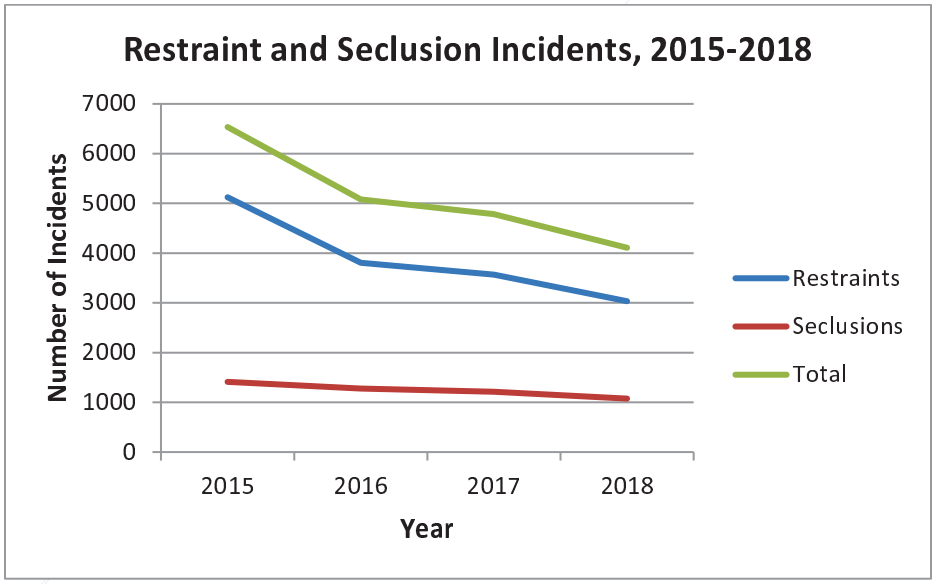
specific documentation of those reviews occurring. Also, there has been no report of findings from those reviews in the annual aggregate report pursuant to RSA chapter 126-U:9, II.

TRENDS IN CONTINUED USE OF RESTRAINT & SECLUSION

The use of restraint and seclusion in New Hampshire facilities is trending downward. Restraint and seclusion incidents decreased by 14 percent from 2017 to 2018 and are down by 37 percent overall since 2015. Individually, restraint incidents are down by nearly 41 percent from 2015 to 2018, while seclusion incidents have decreased at a lower rate, down nearly 24 percent from 2015 to 2018. As seclusions comprise only one-quarter of all incidents, this decline has been largely due to the changing use of restraints. Apart from SYSC, only two residential treatment facilities report the continued use of seclusion.

Combined incidents of restraint and seclusion decreased by 22 percent from 2015 to 2016 and decreased by 6 percent from 2016 to 2017 (Figure 2.). Figures 3. and 4. demonstrate trends in reported restraint and seclusion in the 4-year period from 2015-2018.[105] The incidents involve all children regardless of placing authority.

Figure 2. Combined change in restraint and seclusion incidents over 4 years.



[105] Note: Inconsistencies of data reporting required dropping the 2014 reported data cited in the aggregate of a 5-year period above.

Figure 3. Change in seclusion incidents reported over 4 years

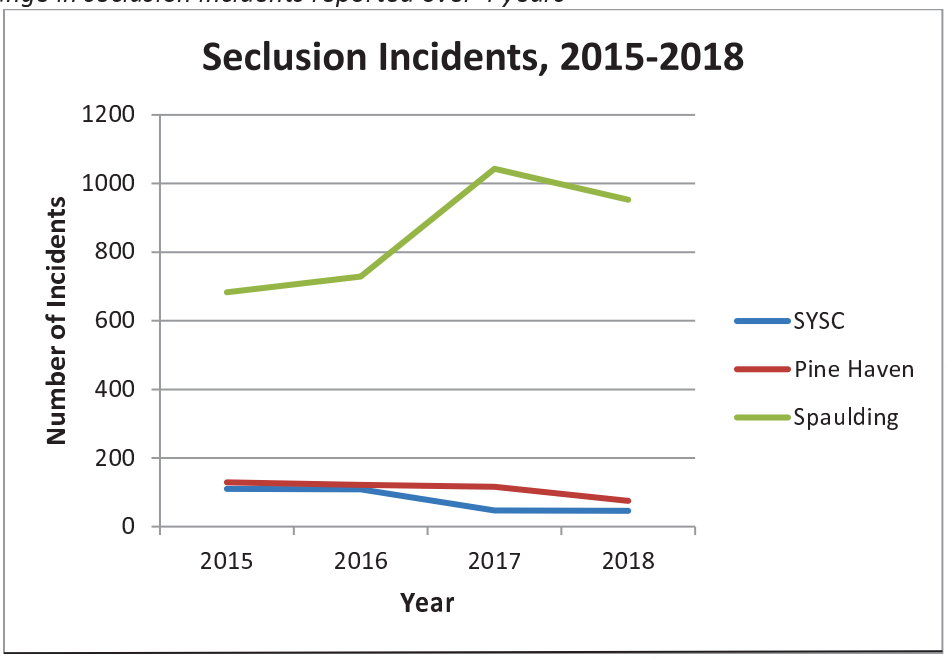
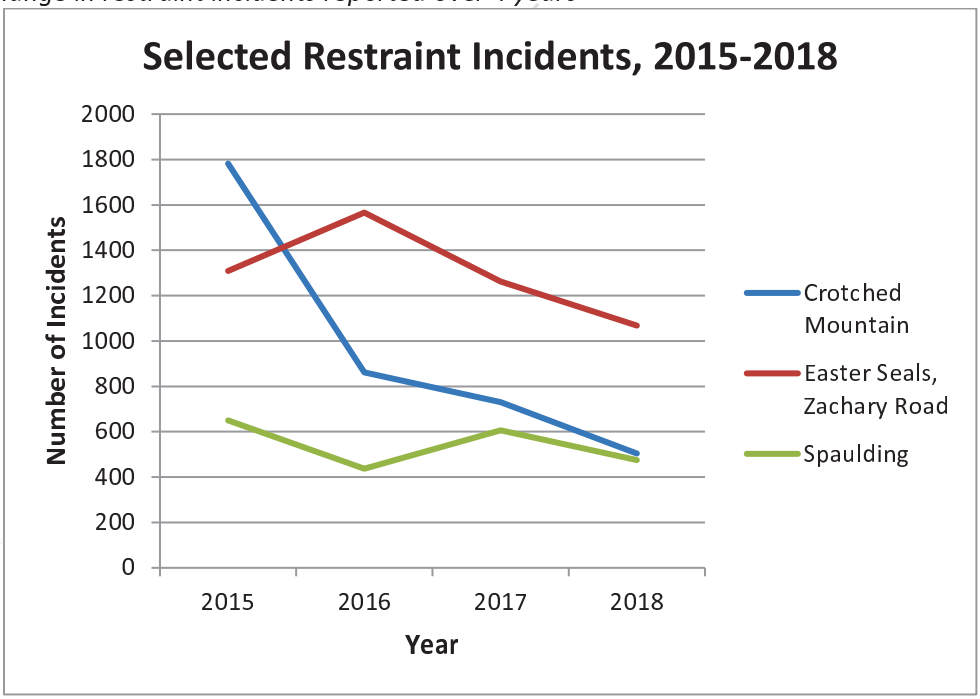


Figure 4. Change in restraint incidents reported over 4 years



Of the 12 residential treatment institutions that reported at least 10 restraints for the 2018 reporting year (from November 2017 to October 2018), 7 institutions reported a decrease in restraint incidents of at least 5 percent from the previous reporting year of 2017, and 4 institutions reported an increase in

restraint incidents of at least 5 percent.[106] One institution saw a decrease in restraints below 5 percent. SYSC had a decrease in restraint incidents of 33 percent. This indicates that the majority of institutions that regularly use restraint have decreased their usage over the past year. In the case of SYSC, this may reflect dramatic change in census, new leadership, staff training in trust-based relational interventions, or all of the above. High statewide incidence of restraint and seclusion persist, however, due to the institutions that continue their usage at the same or even higher levels.

Limits of Restraint & Seclusion Data

This discussion of restraint and seclusion statistics is missing an essential component of analysis. The department only tracks facility census of DCYF-placed children even though they report restraints and seclusions taken together with all children placed, regardless of placing authority. Without detailed and accurate data about the actual census that includes children placed by school systems or other states, reported incidences of restraint and seclusion cannot be directly compared between facilities. Analysis with total census data would yield a much more accurate depiction of the actual incidence of restraint and seclusion when adjusted for population.

As the data currently stand, we cannot distinguish between programs that have high numbers of reported incidents because they serve greater numbers of children and those programs that have high numbers because they actually restrain and seclude children at a higher rate than other facilities. If the OCA or DCYF had thorough information regarding each facility's monthly census, it could be used to monitor restraint and seclusion incidents much more accurately than what is currently reported. This would yield the most insightful and valuable analysis. Because historically there has been no central monitoring of restraint and seclusion data the true incidence of restraint and seclusion per child at each institution is unknown.

TRENDS IN CULTURE CHANGE & STAFF TRAINING

The culture of an organization or agency, including the staff and overall environment, has a significant impact on the frequency of their use of restraint and seclusion.[107] The New York Commission on Quality of Care found that the most important factor in restraint use among different state hospitals was not the severity of patients' mental disabilities, but the management philosophy.[108] Attitudes from the executive administration to nurses and direct care providers on the front line of care must be equally committed to reforming and reducing restraint and seclusion practices in a facility in order for the practice to change. Public reports of alleged abusive restraints have had the effect of vilifying staff. There are systemic factors that contribute to restraints and seclusion over which staff have little control. They include access for the child and family to appropriate care and treatment. Assuming a residential treatment facility has the capacity to meet identified needs of a child, that facility then would need to be philosophically committed to a restraint and seclusion-free environment. That commitment would manifest in proper and continuous training, supervision and well-resourced staff. The key to shifting residential treatment toward restraint and seclusion-free environments successfully starts with

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[106] Note: Three facilities were excluded from analyses due to being new programs with no reports in 2017 for comparison. Nine facilities were excluded as they reported 10 or fewer restraint incidents for the entire year.
[107] Roy, C, Castonguay, A, Fortin, M, et al. (2019). *Supra* note 1.
[108] Sundram CJ, Stack EW, Benjamin WP, (1994). *Restraint and Seclusion Practices in New York State Psychiatric Facilities.* Albany, NY: New York State Commission on Quality of Care for the Mentally Disabled.

leadership commitment. That commitment must be reflected in organizational mission and philosophy adjustment with attentive staff engagement.[109]

DCYF is reportedly in early stages of promoting a system-wide cultural shift to trauma-sensitive, restraint and seclusion-free milieu in certified residential programs. They identified *Six Core Strategies for Reducing Seclusion and Restraint Use© (Six Core Strategies),*[110] a model for reform developed by the National Association of State Mental Health Program Directors (NASMHPD), as a promising therapeutic framework and a means to reduce the aversive and traumatizing use of restraining and secluding children.[111] The Six Core Strategies include steps to build culture, infrastructure, knowledge, and individualized, strengths-based, child and family-driven care. These strategies aim for alternatives to restraining and secluding children. They actually build capacity and effectiveness of treatment and therapeutic milieu so that restraint and seclusion are unnecessary. The strategies include:

1. Leadership toward organizational change – to reinforce facility values and elevate oversight of each incident for immediate review of cause and adjustment of training and policy
2. Use of data to inform practice – to use baseline to trends in occurrences, including pre and antecedent evaluation to understand the interventions' use and progress over time
3. Workforce development – to shift from coercive or conflicting triggering environments to recovery-embraced, trauma-informed therapeutic milieu
4. Use of seclusion/restraint prevention tools – to accommodate evidence-based comprehensive individualized treatment built upon strengths-based needs and risk assessments
5. Consumer roles in inpatient settings – to integrate child, family, advocate and peer support in the oversight of restraint and seclusion use as well as care provision in general to ensure a child-centric, responsive environment
6. Debriefing techniques[112]- to reduce the use of restraint and seclusion through knowledge-building from deep analysis as well as to reduce the traumatizing effects of the interventions on all parties

The Six Core Strategies provide a guiding framework to residential facilities when creating policies and procedures for the reduction of restraint and seclusion. Currently the department has little authority to require this level of practice change and culture shift. DCYF has historically only certified facilities as vendors with minimal expectations or means to influence program design such as can be pursued through contract compliance processes. Currently, certification only requires:

- Licensing and operational approval of the facility
- Board of Education approval when schools are on site

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[109] Husckshorn, KA (2006). *Six Core Strategies for Reducing Seclusion and Restraint Use* ©. National Association of State Mental Health Program Directors. Alexandria, Virginia.

[110] National Association of State Mental Health Program Directors (2006). S*ix Core Strategies for Reducing Seclusion and Restraint Use ©*. At https://www.nasmhpd.org/sites/default/files/Consolidated%20Six%20Core%20Strategies%20Document.pdf.

[111] Azeem, MW, Aujla, A, Rammerth, M, Binsfield, G, & Jones, RB, (2011). Effectiveness of six core strategies bases on trauma informed care in reducing seclusions and restraints at a child and adolescent psychiatric hospital. *Journal of Child and Adolescent Psychiatric Nursing*, 24: 11-15. DOI: 10.1111/j.1744-6171.2010.00262.x

[112] National Association of State Mental Health Program Directors (2006). *Supra note 110.*

- A program inventory of types of treatment offered, population served, capacity, and evidence-based practice employed
- An organizational chart, Board of directors details, staff names/roles, staff training, and policies and procedure

Some providers have reportedly complained the department is over-reaching and interfering with their programs. In August 2019, a DCYF administrator explained to the OCA, "This [promoting the Six Core Strategies] is a new initiative being built into new residential procurements. Right now it is only part of the ERT Female program.[113] They will be expected to implement this and other aspects of the RFP, such as accreditation. Over time it will be part of the program/contract review/monitoring process but it is very much in its infancy having only been added to one procurement for a program, which is only weeks to months along."

The procurement or contract for the ERT Female program the administrator referenced represents the first time the department has contracted for specific residential programming and procedures around the use of restraints. The contract, under Section 2.12.7, requires the contractor develop a quality assurance review process prioritizing the reduction of restraints. It seems a missed opportunity that a brand new program would not open as a restraint-free environment. There was an expectation that certain configurations of furniture would be in place before the facility opened, but not that staff would be trained and therapeutic milieu cultivated making restraint and seclusion unnecessary. Instead, the contract requires reviewing and reporting the use of restraint and seclusion in order to reduce their use. Specifically, the contract requires that the contractor shall:

- Use a nationally recognized program for de-escalation and physical management (2.12.1)
- Institute policy and procedure for use of restraints consistent with RSA 126-U and other laws (2.12.2)
- Provide documentation of any restraints or seclusions to the department (2.12.3)
- Develop a trauma-informed response to the occurrence of restraints in the program that adhere to the Six Core Strategies (2.12.4)
- The program clinician or director must meet with a restrained child immediately following a restraint (2.12.5)
- Administrative reviews must occur the following day and include, at a minimum: the clinician, program director, involved staff, and the child if appropriate (2.12.6,1-4)
- Submit a monthly report of all restraints by the 15th of each month (2.12.7.1)
- The program administrator shall conduct a cumulative review and analysis of restraints on a monthly basis that may include the department (2.12.7.2)
- Submit a quarterly summary report of restraints and overall efforts to reduce them to the Community Program Specialist (2.12.7.3)
- Convene a monthly review meeting of restraint incident, which the department may attend (2.12.7.4)

[113] Note: The ERT Female program is the Becket Family of Services – Mount Prospect Enhanced Program Capacity "Enhanced Residential Treatment" program. Certified to house six females, it is the first residential program in New Hampshire to operate under a department contract. The contract is sole source, 4 years, not to exceed $6,666,144 (6/6/2019).

The fourth item references the Six Core Strategies (the contract actually includes a link to the website for NASMHPD's explanatory document.[114]). However, the language reflects an expectation of *responding* to restraints in adherence to Six Core Strategies, not preventing them: "shall develop a response to occurrence of restraints ..." Without specifically articulating an expectation of restraint-and seclusion free program, provider interpretation will be limited to an obligation to monitor, report and review according to best practice.[115] The OCA has not identified any specific contract compliance measurements in place fr the ERT Female program.

De-Escalation and Crisis Management

While the science is clear on the negative effects of restraint and seclusion, there are still limited resources in place to treat children and resolve problematic behavior. Eliminating restraint and seclusion use must be achieved in concurrence with implementation of community based services and enhancements to effective treatment modalities in residential care. Until restraints and seclusions are eliminated and crisis management is replaced with effective treatment and therapeutic milieu, training in de-escalation techniques remains essential for residential treatment staff. Ensuring adequacy of staff training to provide safe care for state-placed children in residential facilities is another area limited by lack of state contracting for services. In July 2019, the department surveyed residential providers to determine which, if any, de-escalation or crisis management training programs the facilities used.

The results revealed the majority of New Hampshire facilities, seventeen, currently employ Therapeutic Crisis Intervention (TCI). The TCI model aims to eliminate the need for restraint by training staff for "preventing crises from occurring, de-escalating potential crises, effectively managing acute crises, reducing potential and actual injury to children and staff, learning constructive ways to handle stressful situations, and developing a learning circle within the organization."[116] Four residential facilities employ the Crisis Prevention Institute (CPI) model of nonviolent crisis intervention.[117] CPI promotes the understanding of behavior as a form of communication. Training includes prevention and de-escalation techniques. According to a CPI training advisor, CPI training includes some physical intervention that may meet the definition of restraint in some state laws; however, the emphasis is on using physical intervention in emergencies only. The model emphasizes continuous assessment and proactive intervention before a situation elevates to necessitating restraint. Not all CPI training includes physical restraint. It depends upon the facility. The fidelity of model is also dependent upon the facility.[118] The four facilities reporting CPI as crisis management model are also the four facilities reporting continued use of prone restraint, which does not appear aligned with the philosophy of the model.

Recognizing the importance of staff training and the burden of training expense to facilities, the OCA inquired of the department in July, 2019 how residential treatment providers are supported to reduce restraint and seclusion through department-sponsored or facilitated training. The OCA asked three questions:

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[114] https://www.nasmhpd.org/sites/default/files/Consolidated%20Six%20Core%20Strategies%20Document.pdf
[115] Azeem, MW, Aujla, A, Rammerth, M, Binsfield, G, & Jones, RB, (2011). *Supra note 111.*
[116] TCI website. Accessed at http://rccp.cornell.edu/tci/tci-1_system.html.
[117] https://www.crisisprevention.com/About-Us
[118] Personal communication, January 2019

- What state-sponsored training is available to residential providers to impact use of restraint and seclusion?
- How many providers have participated?
- How many staff from each provider have participated?

A department staff responded explaining there was training support in multiple residential programs and noted the emergence of trust-based relational intervention (TBRI) as a promising model. The OCA was not able to access specifically what trainings have been offered, how many providers take advantage of training opportunities through the state training system at Granite State College, or how many staff have participated. A full account of the degree to which the department has assured training to minimize the use of restraint and seclusion has yet to be identified. Several administrators pointed to the well-attended DCYF Annual Conference at which, in addition to DCYF staff, many residential providers participated. However, it is not clear to the OCA how many provider staff participated in the learning sessions. At least one provider group was present but reportedly did not attended any learning sessions.

Trust-based Therapeutic Milieu

TBRI, referenced by the department staff, in the statement above, appears to be under consideration for implementation in several New Hampshire residential facilities. The OCA has elsewhere reported its implementation at the SYSC.[119] At least one other residential treatment provider, Spaulding Youth Services, reported training a large percentage of staff in this model of treating complex trauma in children. TBRI emphasizes three pillars of healing and development: safety, healing relationships, and coping skills.[120] The principles of TBRI are aligned with the issues of child development and trauma exposure outlined above in the section on child development. The approach acknowledges a child's basic physical needs, as well as the needs for consistent relationships, and opportunities for positive, proactive socialization. Implementation of the TBRI model essentially establishes a culture of developmental nourishment. While there is no specific step-by-step guidance to achieving a trust based culture in a facility, the complexity of meeting children's needs through TBRI makes apparent the complexity of knowledge that must be acquired, beyond training sessions alone. Assuring a child's safety requires taking steps for that child to feel safe, not just be determined safe as discussed in the section on safety.

TBRI principles of safety include attention to varying levels of transition, whether developmentally, in a daily routine or in major life events such as removal from home, court hearings, or birthdays. Children with trauma exposure may have sensory sensitivities that translate to behavior, social skills or school performance. Identifying the root of a function such as refusing to sit in a classroom, creates an opportunity to address the child's sense of discomfort and create safe space to focus on schoolwork. Nutrition is another area of creating safety for children in the TBRI model. Prenatal exposure to substances and early hardships actually have long term impact on physiological conditions, including maintaining healthy blood sugar levels. Adequate sleep and regular physical exercise, essential components of TBRI, are also critical to a child's well-being and mental functioning.

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[119] Office of the Child Advocate, State of New Hampshire, *2018 Annual Report.* Concord: Office of the Child Advocate

[120] Purvis, KB, Cross, DR, Dansereau, DF, & Parris, SR (2013). *Supra note 3*.

When promoting relationships in a TBRI milieu, facility staff are challenged to hone observation skills in order to recognize and interpret accurately a child's nonverbal communications. In order for a child to connect healthfully, they must first gain a sense of autonomy. Negotiating and compromising versus enforcing arbitrary facility rules builds both trust and autonomy. These principles apply in nurturing a child's self-correcting behavioral and coping skills. Many children have learned violent, manipulating and even self-harming behaviors as a means to keep themselves safe and get their needs met. Interpreting these behaviors for what they are and positively, proactively nurturing pro-social behaviors or forms of communication takes patience and craft that must be cultivated through repeated trainings, debriefings and supervisory guidance. The account of a staff person "using Trust Based Intervention" to stop a boy from running in Incident Narrative D. below, demonstrates an appreciation of de-escalation. However, the reference to TBRI suggests a somewhat superficial understanding of the deeper culture-changing approach that comprises the model.

Incident Narrative D.
"Ricky" and "Nate"
Incident: According to a staff incident report, "Ricky" kicked "Nate's" basketball in the gymnasium. Nate approached Ricky as if to fight him. A staff person stepped between the two using opened hand guidance but the boys were still aggressive towards each other. Other staff intervened and Nate was escorted away. While a staff was guiding Ricky, the boy pushed off him and shouted profanity at him. Ricky then kicked another basketball and started back towards the gymnasium. The staff reported, "I then attempted to use Trust Based Relationship Intervention (TBRI) when Ricky started running toward the gym entrance." The staff documented using a "Mach 2 to subdue Ricky to the ground to prevent him from going after" the other boy.

At the SYSC, a reported 55 staff members have attended an initial training for TBRI with two in-house trainers. Although the SYSC claims to have seen a reduction in restraint incidents since the implementation of these trainings, they were unable to provide actual data or any measurements of outcomes associated with staff training in TBRI. An administrator explained, "There is nothing formal provided by TCI or TBRI." Determining TBRI effect is confounded by factors, including significant changes in the facility census. With such low census and TBRI training, the expectation should be elimination of restraints or seclusion, a goal an administrator has professed.

Organizational culture change is an enormous undertaking, requiring commitment and resources. Implementation is not just a matter of training. It requires a carefully designed, intensive immersion in learning, skills building, and adjusting value systems. One department administrator described successful transformation in another state that implemented Six-Core Strategies to reduce restraint and seclusion use successfully. The initiative used facility-dedicated consultants to act as guides or coaches and change agents. These kinds of investments in resources reflect commitment to quality care for children. Support for these transitions would not only position residential facilities for safe practices and decreased use of restraint and seclusion; it would push facilities forward in effective, efficient care practices.

FAMILY FIRST PREVENTION SERVICES ACT OF 2018

The federal Family First Prevention Services Act of 2018 (Family First) went into effect October 1, 2019. The aim of the paradigm-shifting legislation is to limit the number of children in out-of-home placements and the time they spend there, by increasing prevention services and family supports. This initiative acknowledges advances in brain science and understanding of child development that recognizes out of home placements as adverse childhood experiences. The law sets rigorous requirements for placement in residential treatment programs to ensure optimal use of federal funding. New Hampshire is not yet ready to implement the law. The department has proposed a system re-design that will bring the state systems of care on par with the federal expectations.

Under Family First, residential treatment facilities must meet the standards of a "qualified residential treatment program" (QRTP) in order for states to access federal IV-E funds for reimbursing that institution. One of the key requirements for QRTP status is accreditation by one of three accrediting bodies: Commission on Accreditation of Rehabilitation Facilities (CARF), Joint Commission, or Council on Accreditation (COA). Among other requirements, accrediting bodies have specific expectations for safety and therefore the use of restraint and seclusion. Joint Commission accreditation standards emphasize "building a culture of safety and respect," within which restraint and seclusion are deemed "intrusive, have a potential for harm, and may be traumatizing."[121] An organization's philosophy must include "[i]ts responsibility to facilitate the discontinuation of restraint or seclusion as soon as possible" and a commitment to "[p]reserving the safety and dignity of the individual served when restraint or seclusion is used."[122] Until the facility is restraint- and seclusion-free, any incident of either action requires a protocol of specific response, including monitoring a restrained or secluded child through continuous in-person observation by a trained staff member,[123] and a debriefing within 24 hours with the child, the staff members who were involved in the incident, and the child's family "if appropriate."[124] Additionally, Joint Commission standards prohibit "the use of restraint techniques that restrict the flow of air to the individual's lungs,"[125] which includes prone positioning. The external pressures of achieving QRTP status represents an opportunity and incentive for program redesign and re-thinking use of restraint and seclusion in residential treatment facilities.

At this writing, only one residential treatment facility in New Hampshire is accredited, the NFI North Davenport School. That program has also consistently reported no incidents of restraints in recent annual reports. Two other facilities, Easter Seals and Pine Haven, have completed accreditation and entered a six-month review period. Adjusting other facilities' practices and therapeutic milieu to meet accreditation standards may be an expensive undertaking. In addition to other considerable enhancements including employment of licensed staff prepared to provide evidence-based programming, complying with accreditation standards for therapeutic alternatives to restraint and seclusion will require intensive staff training. In the absence of federal financial support, the responsibility falls to providers or DCYF to fund the re-design. The 2020-2021 Budget contained a small amount (approximately $30,000 per qualified facility) for "system redesign" to assist providers with the

[121] Joint Commission (2019). Standards and Elements of Performance for Restraint Accredited as a Behavioral Health Program, CTS.05.06.01.
[122] Joint Commission (2019).*Supra note 121.*
[123] Joint Commission (2019).*Supra note 121,* CTS.05.06.27.
[124] Joint Commission (2019).*Supra note 121,* CTS.05.06.31.
[125] Joint Commission (2019).*Supra note 121,* CTS.05.06.25.

process of accreditation. That is a start. The key finding noted above regarding the necessity of organizational leadership commitment to restraint and seclusion-free environments means ensuring staff training and organizational cultural shifts are supported and sustained, both within residential treatment facilities and the department itself.

CONCLUSION

RSA Chapters 169-B, C, and D require DCYF ensure a child has access to whatever therapeutic services are necessary for optimal development and wellbeing. A big part of that responsibility is to understand children in general – how they develop, what has interrupted their development and what treatments match their needs. If all actions are informed in this way, there will be little need for restraint and seclusion. In this line of thinking, it is easy to view restraint and seclusion as human error or preventable adverse events the way federal reimbursement structures do.

The evidence is clear. Restraint and seclusion do not help. In fact, they are practices that harm children, staff and the whole organization in far reaching ways. Prone restraints are especially dangerous, even potentially lethal. Steps are in place for change and external forces in the form of Senate Bill 14, the Family First Prevention Services Act, and even the possibility of federal reimbursement limitations. In order for the department to meet its mandates under Chapters 169-B, C, and D, implementation of community-based services and rapid mobile response must start rolling out to help children where they are and avoid the adverse effect of home removal and residential placement. In the meantime, DCYF has to watch children already removed from their homes and those who will be exceptions in future. Ensuring appropriate care is essential to child safety and wellbeing. It is also necessary to the optimal functioning of the system. Engaging providers in pursuit of trust-based, trauma-informed, comprehensive individualized care for children must be accompanied by mechanisms such as contracts and laws that facilitate accountability. They also require supports in the form of training, resources for the accreditation process, and guidance in cultural shifts.

The OCA has continued over the past two years to encourage and nudge the department along toward proper oversight of the restraint and seclusion of children in residential treatment facilities. Whether it has been through the OCA's continuous efforts, the specter of a public report on the horizon, or just the natural progression of understanding the negative impact of restraint and seclusion on the well-being of children, the department at last is building a system of surveillance to monitor incidents of restraint and seclusion on children for whom the department holds a great deal of responsibility. The challenge will be to build systems for consistency of data and data collection. For the system to work, it will have to include monitoring and analyzing the data to ensure identification and dispensation of patterns in incidents that show a need for system improvements. Adopting rules, as the law demands, will help the department demonstrate transparency, assure consistency, and accountability. As the department shifts to contracting for services, there must be attentive and timely assessment of contract compliance. Starting with the current contract for the ERT Female program, the department should be measuring implementation of the Six Core Strategies, reviewing staff training content and participation, attending incident reviews and monitoring response to incidents, and listening to the children about their perceptions of adequacy, effectiveness and safety of care. This report has focused on the use and reporting of restraints and seclusion in New Hampshire facilities. There are routinely approximately 70 children placed in out-of-state residential treatment facilities. The OCA has yet to account for their treatment or risk of restraint and seclusion.

RECOMMENDATIONS

Minimize Trauma

- Implement community-based system of care expansions outlined in 2019 Senate Bill 14 and promote effective alternatives to institutional placements (department)
- Enhance department staff training, including Sununu Youth Services Center (SYSC) staff, in child development with emphasis on brain development and impact of trauma, (department)

Adopt and Clarify Language

- Adopt and clarify language in contracts, guidance, policy, procedure and adopted rules to clearly articulate the expectation of minimizing and eliminating restraint and seclusion and, as per RSA 126-U, prohibiting restraints equating to prone restraint (department, providers)

Incentivize Culture Change

- Sponsor training in child development, trauma, and trust-based relational interventions for residential treatment staff in a shift to trust-based, trauma-sensitive, developmentally informed, effective care and treatment models (department, providers)
- Capitalize on existing educational infrastructure in the DCYF-Granite State College training programs by extending opportunities to all residential treatment staff. (department, providers)
- Promote, monitor and hold accountable residential treatment facilities seeking to achieve status as a federally qualified residential treatment program under the Family First Prevention Services Act including support for coaching consultants for shifting culture (department)

Facilitate Meaningful Surveillance

- Adopt rules pursuant to RSA 126-U:9, policies and/or practice guidance for reporting incidents, reviewing practices, investigating abuses, ensuring remedial and protective measures, and receiving complaints (department)
- Conduct periodic, reviews of facility practices and reports in accordance with RSA 126-U:9, II for the basis of the annual report regarding the use of restraint and seclusion (department)
- Develop a web-based standardized reporting mechanism for provider ease of reporting incidents with consistent, meaningful data, including facility census (department)
- Comply with 170-G:18 by providing the OCA immediate access to records, including the shared drive where incident data is currently being stored (department)
- Develop a monitoring system to oversee all children placed in institutional settings, including those placed by school districts (legislature, department, Department of Education)
- Establish a collaborative for regular review of restraint and seclusion incidents. Include the department, providers, the OCA, the DRC, individuals who, as children, experienced residential placement, and families (department)
- Develop a process for children currently in the system to share their experience and make recommendations to the collaborative (department)
- Examine the logistical obstacles to the department's mandate of 48-hour incident reporting to the OCA under RSA 170-G:18, IV(a) and adjust the mandate, if necessary (legislature, department, OCA)